PRINTED: 07/20/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495394	B. WING		C 06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
E 000	Initial Comments		E 00	0		
E 026 SS=C	survey was conducte 06/22/18. Correction compliance with 42 of Requirement for Lon complaint was inves Roles Under a Waive	ns are required for CFR Part 483.73, g-Term Care Facilities. One tigated during the survey. er Declared by Secretary	E 02	6	8/3/18	
	develop and implem policies and proceduplan set forth in para assessment at paragand the communicat this section. The policies and update	cedures. The [facilities] must ent emergency preparedness ures, based on the emergency graph (a) of this section, risk graph (a)(1) of this section, ion plan at paragraph (c) of cies and procedures must be ed at least annually. At a s and procedures must g:]				
	[facility] under a waiv in accordance with s provision of care and), or (9)] The role of the ver declared by the Secretary, ection 1135 of the Act, in the ditreatment at an alternate by emergency management				
	procedures. (8) The waiver declared by the with section 1135 of at an alternative care management official This REQUIREMEN by:	T is not met as evidenced				
	review it was determ	view and facility document ined that the facility staff		The Laurels of Bon Air wishes to have this submitted plan of correction stand	as	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

07/13/2018 **Electronically Signed**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		495394	B. WING _			C 06/22/2018		
NAME OF PE	ROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE ! ALIE	SELO OE DON AID			91	01 BON AIR CROSSINGS DRIVE			
THE LAUR	RELS OF BON AIR			В	ON AIR, VA 23235			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
E 026	'		E0	26				
	failed to have a comp preparedness plan.	lete emergency			its allegation of compliance. Our date alleged compliance is August 3, 2018. Preparation and/or execution of this pla			
	The facility staff failed	I to develop policies and			of correction does not constitute	411		
		ergency plan that describe			admission to, nor agreement with, either	er		
	•	oviding care and treatment			the existence of or the scope and seve	rity		
	at altered care sites u			of any of the cited deficiencies, or	_			
	The findings include:			conclusions set forth in the statement of				
	The findings include:				deficiencies. This plan is prepared and executed to ensure continuing complia			
	On 06/21/18 at 3:00 r	o.m. a review and interview			with regulatory requirements.	1100		
	•	ency preparedness plan was			3, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,			
	conducted with ASM	(administrative staff			A description of the facility's role in			
		ninistrator. Review of the			providing care and treatment at an			
		reparedness plan failed to			alternate care site under the 1135 waiv	er		
	evidence policies and				has been written.			
		describe the facility's role in eatment at altered care sites			All residents have the potential to be affected.			
	•	r. ASM # 1 stated he would			The Administrator will be educated on	he.		
	look for it.			regulation requiring a description of ho the facility will provide care at an altern	W			
	On 06/22/18 at appro	ximately 8:00 a.m., ASM # 1			care site under an 1135 waiver.			
	provided this survey v	with a document entitled			The Administrator has audited the			
		Treatment at an Alternate			Emergency Preparedness Plans and h	as		
		Waiver." ASM # 1 stated			updated the plan with the written			
		is put together the evening			description of the facility's role under a	n		
	before.				1135 waiver.	d		
	On 06/22/18 at appro	ximately 12:00 p.m., ASM			Continued compliance will be monitore through the facility's quality assurance	a		
		nember) # 1, administrator,			program. Additional education and			
		nursing were made aware of			monitoring will be initiated for any			
	the above findings.	-			identified concerns.			
	No further information	n was provided prior to exit.						
F 000	INITIAL COMMENTS		F 0	00				
	An unannounced Me conducted from 6/19/	dicare/Medicaid survey was 18 through 6/22/18.						

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			72525	<u> </u>		С	
		495394	B. WING _		0	6/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235			
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F 000	following 42 CFR Par Term Care requireme survey/report will follo investigated during so The census at this 12 112 at the time of the consisted of 28 curre 94, 109A, 108, 43, 32 81, 64, 308, 22, 23, 5	red for compliance with the t 483 of the Federal Long ents. The life safety code ow. One complaint was survey. 24 certified bed facility was survey. The survey sample int residents, (Residents # 2, 309, 1, 102, 158, 311, 37, 11, 6, 20, 9, 46, 67, 50, 39, and four closed records,	F 0	00			
F 550 SS=D	Resident Rights/Exer CFR(s): 483.10(a)(1) §483.10(a) Resident The resident has a rig self-determination, ar access to persons an	cise of Rights (2)(b)(1)(2) Rights. ght to a dignified existence, and communication with and	F 5	50		8/3/18	
	with respect and dign resident in a manner promotes maintenand	and in an environment that be or enhancement of his or ognizing each resident's lity must protect and					
	access to quality care severity of condition, must establish and m practices regarding tr	cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.					

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F 550	rights as a resident or or resident of the Unit §483.10(b)(1) The fact resident can exercise interference, coercion from the facility. §483.10(b)(2) The residence of interference, coreprisal from the facility rights and to be supplexercise of his or her subpart. This REQUIREMENT by: Based on observation interview and facility determined that the fact a resident's dignity do one of 32 residents in Resident # 32. The facility staff failed covered during incommon the findings included Resident # 32 was as 08/12/16 with diagnosinot limited to Alzheim	of Rights. right to exercise his or her if the facility and as a citizen ted States. cility must ensure that the is his or her rights without in, discrimination, or reprisal sident has the right to be exercison, discrimination, and ity in exercising his or her orted by the facility in the rights as required under this is not met as evidenced in, resident interview, staff document review, it was acility staff failed to maintain uring incontinence care for in the survey sample, it to keep Resident # 32 tinence care.	F	550	Resident #32 suffered no adverse effe and did not require transfer to a higher level of care. Resident #32 is receiving incontinence care daily and protocols for dignity are being followed. A quality review of current residents receiving incontinence care has been performed. Licensed Nursing Staff re-educated by DON/Designee regarding ensuring that privacy curtains are used when providing care to residents.	or		
	the initial tour of the f	ximately 6:30 p.m., during acility an observation of Resident # 32's room was			DON/Designee to conduct quality monitoring for the use of privacy curtain during resident care five times a week weekly x4 weeks and then monthly, PR and as indicated.	x1,		

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F 550	conducted. During to door was closed. We the door, staff inside Upon entering the room, Resident and Beside of the room, Resident and Beside of the room, It privacy curtain betwoeds was pulled appropriately beds was pulled appropriately as a pulled appropriately waist to her feet. Further Resident # 32 was under feet exposing the wearing. Resident and were present in the subservation on the Arwere observed crown closed privacy curtain Resident # 32's most set), a quarterly asset (assessment referent Resident # 32 as so interview for mental - 15, 0 (zero) - being cognition for making 32 was coded as record one staff member on 06/22/18 at 8:20 conducted with CNA 1. When asked to distinct the room of the resident with the conducted with the conduc	the tour Resident # 32's room then this surveyor knocked on the room stated to come in. toom and standing just inside # 32 was observed on the the enext to the window, the the observation revealed the covered from her waist to the brief Resident # 32 was the side of the room. They ded behind the partially the enext to the window, the the recent MDS (minimum data the enext to the waist to enext to the window, the the recent MDS (minimum data the enext to the the room. They ded behind the partially tin. It recent MDS (minimum data the enext to the the room. They ded behind the partially tin. It recent MDS (minimum data the enext to the the room. They ded behind the partially tin. It recent MDS (minimum data the enext to the the room. They ded behind the partially tin. It recent MDS (minimum data the enext to the the room. They ded behind the partially tin. It recent MDS (minimum data the enext to the the room. They ded behind the partially tin. It recent MDS (minimum data the enext to the the room. They ded behind the partially tin. It recent MDS (minimum data the enext to the the room of the the	F 550	,	d. e		
	maintaining a reside incontinence care to "During care I keep body I'm working on gown if they are weathe reasonable persexposed like, Reside	•					

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F 550	no one would want to who is not taking care modesty would be vious Attempts were made survey to interview Rand visitor who was probservation of Reside attempts were unsucurnavailability of Reside visitor. The facility's "Resider Responsibilities" doct Rights. The resident existence, self reside communication with a services inside and of those specified in this Respect & Quality of each resident with resident with resident resident with resident with resident resident in a environment that profer each resident in a environment that profer each resident." On 06/22/18 at approfed (administrative staff in ASM # 2, director of in the above findings. No further information References: (1) A brain disorder the	It feel comfortable because be exposed to someone of them and their sense of plated." during the days of the esident # 32's roommate present during the ent # 32 on 06/19/18. The cressful due to the dent # 32's roommate and the latest and lat	F	550			

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F 550	https://www.nlm.nih.gsease.html. (2) Fear. This inform website: https://www.nlm.nih.gsummary. (3) A swallowing discobtained from the wehttps://www.nlm.nih.gsorders.html.	ined from the website: gov/medlineplus/alzheimersdi nation was obtained from the gov/medlineplus/anxiety.html	F 58			8/3/18
SS=D	S483.10(g)(14) Notificity A facility must immonsult with the residence consistent with his or representative(s) who (A) An accident involvesults in injury and head to alter the clinical complications (C) A need to alter the aneed to discontinuate treatment due to advice commence a new for (D) A decision to transection (E)	cation of Changes. nediately inform the resident; lent's physician; and notify, ther authority, the resident en there is- ving the resident which has the potential for requiring n; nge in the resident's physical, cial status (that is, a h, mental, or psychosocial reatening conditions or s); eatment significantly (that is, e an existing form of erse consequences, or to rm of treatment); or usfer or discharge the				

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F 580	is available and proving physician. (iii) The facility must a resident and the resident as specified in §483. (B) A change in resident as specified in §483. (B) A change in resident as the section (iv) The facility must represent a specified in §483. §483.10(g)(15) Admission to a competitudent as a composite di §483.5) must disclose its physical configurational configurational that comprise part, and must specified room changes between under §483.15(c)(9). This REQUIREMENT by: Based on observation interview, facility document of the survey with was failed to notify the phypractitioner and/or resident and and a physician and/or nursident a	on specified in §483.15(c)(2) ded upon request to the also promptly notify the lent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph . eccord and periodically mailing and email) and	F	580	The Physician has been notified of resident #23s non-compliance of her 1200cc per 24 hours fluid restriction. Resident #311 did not require transfer higher level of care and did not sustain any adverse effects. The Physician habeen notified of resident #50s transfer higher level of care following blood sug of 50. A quality review of residents with physician orders for fluid restrictions had	is to a lar	

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NAME OF D	ROVIDER OR SUPPLIER	493394		CT	FREET ADDRESS, CITY, STATE, ZIP CODE	00	6/22/2018
NAME OF PI	ROVIDER OR SUPPLIER				, , ,		
THE LAUF	RELS OF BON AIR				01 BON AIR CROSSINGS DRIVE		
				B	ON AIR, VA 23235		
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F 580	Continued From page	e 8	F 5	80			
	6/2/18, 6/4/18, and 6/	/14/18.			been performed.		
	, , , , , , ,				A quality review of residents in the facil	ity	
	2. The facility staff fai	led to notify the physician			has been performed for medication	,	
	that Resident #311's	medications were not			administration and documentation. A		
	available for administ	ration.			quality review of residents with orders	for	
					accu-checks has been performed.		
		led to notify the physician					
	when Resident #50's	blood sugar reading was 50.			Licensed Nurses will be educated by		
					DON/Designee regarding notifying the		
	The findings include:				Physician of medications not		
	4 The feeility staff fe	iled to motify Decident #201s			administered, resident non-compliance	tor	
	-	illed to notify Resident #23's se practitioner of Resident			fluid restrictions and abnormal blood sugars. DON/Designee during morning	. ~	
		with her 1200 cc (cubic			clinical meeting to conduct quality	ıy	
		ours fluid restriction on			monitoring of Physician notification of		
	6/2/18, 6/4/18, and 6/				abnormal blood sugars, resident		
					non-compliance with fluid restriction ar	ıd	
	Resident #23 was ad	mitted to the facility on			medications not administered, 5x week		
	2/28/18, with diagnos	ses that included but were			weeks, weekly x4 weeks and then		
	not limited to: heart d	isease, high blood pressure,			monthly and PRN and as indicated.		
		odium level in the blood) (1),					
	•	ental illness which includes			Findings to be communicated to the Q	4	
	unusual mood change	es) (2), and muscle			committee monthly and as indicated.		
	weakness.				Quality monitoring schedules modified		
	The most recent MDS	C (minimum data set)			based on findings.		
	The most recent MDS	s (minimum data set) erly assessment, with an					
	-	ference date) of 4/4/18,					
	,	s scoring a 15 on the BIMS					
		ental status) score, indicating					
		itive impairment. She was					
		erstanding others and					
	_	If understood. Resident #23					
		ng extensive assistance of					
		mbers for bed mobility,					
	transfers, toileting, an	nd personal hygiene.					
		rehensive care plan dated ecent revision on 3/12/18,					

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F 580	and/or dehydration Rappetitehyponatre restriction." In the In need it is documented it is documented an order of the strictions as ordered A physician's order with documented an order every 24 hours 1200 order does not have A nurse practitioner of documented in partitests): [sodium] 136 sodium levels is 135 liter (mEq/L) (3)]hy continue fluid restrict A review of Resident documents that Resi ordered fluid amount of 1600 cc, on 6/4/18 cc, and on 6/14/18 whas A review of the nurse 6/20/18 failed to docieither the physician of Resident #23's exceed amount on these data. On 6/20/18 at 08:58 conducted with Resident asked about the nurron her bedside table told me I could drink.	"Need: At nutritional risk t/T (related to): decreased mia, diuretic use and fluid terventions section of this d in part, "Follow fluid ted." with a start date 3/6/18 of 1200 cc QD (every day) cc fluid restriction. This a discontinuation date. The dated 6/20/18 The dated 6/20/18 The rinent labs (laboratory formal range for blood to 145 milliequivalents per reponatremia ongoing, ion." #23's fluid intake report dent #23 exceeded the on 6/2/18 with a fluid intake with a fluid intake of 1400 ith a fluid intake of 1540 cc. The start date 3/6/18 The date	F	580			

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F 580	When asked who to responded, "The state of the control of the daily stated the fluids from and any amount the medications. When the daily fluid intake stated "Yes, we tell to they tell us the amount and was asked abour estriction was exceresident sneaks so dommunicated to the "Yes." On 6/21/18 at 2:25 producted with LPN LPN #7 confirmed the communicate with eithe CNAs know how receives when taking asked what nursing exceeded the daily I document it. When physician or nurse producted or report of know. Review of the June in the state of the communicate with the communicate or nurse producted or nurse producted or report of know.	Inducted on 6/21/18 at 2:20 fied nursing assistant) #4. exactly what fluids are y intake report. CNA #4 in the resident's food trays nurses give the resident with asked if she communicated is to the nurses, CNA #4 the nurses the amount, then nur from medications, and it is the report." CNA #4 was ke report for Resident #23 at the days where the fluid eded. CNA #4 stated, "The as." When asked if this was e nurses, CNA #4 stated	F 58			

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F 580	conducted with ASM member) #3, the nur asked if she or the p when fluid restriction stated "Yes." ASM # intake report for Jun was unaware of the Resident #23 on 6/2 however, she did ac was known to be occher ordered care. ASM #1 (the administ of nursing), ASM #4 operations), and ASI coordinator) were m concern on 6/22/18 in No further information following website: https://medlineplus.g(2) This information following website: https://medlineplus.g(3) The facility staff fat that Resident #311's available for administ	a.m., an interview was (administrative staff rise practitioner. ASM #3 was hysician should be contacted as are exceeded. ASM #3 f3 was shown the daily fluid be 2018. She stated that she exceeded fluid intakes for f18, 6/4/18 and 6/14/18; knowledge that Resident #23 casionally noncompliant with strator), ASM #2, (the director f18 (the regional director of f19 (the regional clinical f19 (the regional clinical f19 (the regional clinical f19 (the above f19 (the regional clinical f19 (the above f19 (the regional clinical f20 (the re	F 5	80		

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		495394	B. WING _			C 6/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		012212010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	6/8/18 with diagnoses limited to: infection of irregular heart beat, of pressure and urinary. The most recent MDS admission assessment reference date) of 6/1 having scored a 12 of interview for mental swas moderately impa. Review of the resident 6/21/18 documented, for decreased Cardial HTN (hypertension), irregular heartbeat), a failure). Interventions ordered. "Review of the physicit documented, "Amioda MG (milligrams). Give a day for AFIB (atrial heartbeat). Start Date Succinate XL (2) Give a day for HTN (hypertension) (106/09/2018. Keppra (106/09/2018. Midrodin Start Date: 06/09/201 give by mouth. Start Date: 06/09/201 give by mouth. Start Date: 06/09/201 give by mouth. Start Date: 06/08/2018."	s that included but were not the hip, heart failure, liabetes, high blood tract infection. 6 (minimum data set) an int with an ARD (assessment 5/18 coded the resident as ut of 15 on the brief tatus, indicating the resident ired to make daily decisions. 1t's care plan initiated on "Focus. CARDIAC: At risk to Output R/T (related to): A-Fib (atrial fibrillation an and CHF (congestive heart and CHF (congestive heart and CHF (1) Tablet 200 to 1 tablet by mouth one time fibrillation an irregular to 100 mg by mouth one time tension). Start Date: 3) Give 500 mg by mouth elezures. Start Date: e (4) 5 mg Give by mouth the electron of tablet by mouth and cart Failure. Start Date: 1018 MAR (medication)	F 5	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495394	B. WING				22/2018
	ROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE CON AIR, VA 23235	1 001	22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Give 1 tablet by mout (atrial fibrillation an Date: 06/09/2018." Onurse's initials were of "Metoprolol Succinate one time a day for HTDate: 06/09/2018. "Onurse's initials were of "Keppra Give 500 mg for Seizures. Start Data "5" and the nurse's 9:00 a.m. and 5:00 p. "Midrodine 5 mg Give 06/09/2018." On 6/9 and 8:00 p.m. and on 1:00 p.m. a "5" and the documented. "Oxybutynin 2.5 mg g 06/09/2018." On 6/9/p.m. and on 6/10/18 a "5" and the nurse's in "Spironolactone 25 mone time a day for He 06/08/2018." On 6/9 a "5" and the nurse's in Review of the chart of documented, "5= Hol Review of the nurse's "6/9/2018 15:10 (3:1)	blet 200 MG (milligrams). th one time a day for AFIB irregular heartbeat). Start in 6/9/18, a "5" and the locumented. EXL. Give 100 mg by mouth in 6/9/18 a "5" and the locumented. By mouth two times a day ate: 06/09/2018." On 6/9/18, initials were documented at im. By mouth. Start Date: 18 at 9:00 a.m., 1:00 p.m. 6/10/18 at 9:00 a.m. and the nurse's initials were Live by mouth. Start Date: 18 at 9:00 a.m. and 5:00 at 9:00 a.m. and 5:00 p.m. a itials were documented. In g Give 1 tablet by mouth the part Failure. Start Date and 6/10/18 at 9:00 a.m., a itials were documented. In g Give 1 tablet by mouth the part Failure. Start Date and 6/10/18 at 9:00 a.m., a itials were documented. In g Give 1 tablet by mouth the part Failure. Start Date and 6/10/18 at 9:00 a.m., a itials were documented. In g Give 1 tablet by mouth the part Failure. Start Date and 6/10/18 at 9:00 a.m., a itials were documented. In g Give 1 tablet by mouth the part Failure. Start Date and 6/10/18 at 9:00 a.m., a itials were documented. In g Give 1 tablet by mouth the part Failure. Start Date and 6/10/18 at 9:00 a.m., a itials were documented. In g Give 1 tablet by mouth the part Failure. Start Date and 6/10/18 at 9:00 a.m., a itials were documented. In g Give 1 tablet by mouth the part Failure. Start Date and 6/10/18 at 9:00 a.m., a itials were documented.	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495394	B. WING				22/2018
	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	<u>, </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	mouth one time a day pharmacy; 6/9/18 15:13 (3:13 p.i Administration Note. Give 100 mg by mouth Awaiting pharmacy; 6/9/18 15:13 eMar (eladministration record Note. Metoprolol Such mouth one time a day pharmacy; 6/9/18 15:13 eMar (eladministration record Note. Midrodine 5mg pharmacy; 6/9/18 15:14 eMar (eladministration record Note. Oxybutynin 2.5 Pharmacy; 6/9/18 15:14 eMar (eladministration record Note. Oxybutynin 2.5 Pharmacy; 6/9/18 15:14 eMar (eladministration record Note. Spironolactone mouth one time a day pharmacy. " There was no evident physician had been in An interview was contain. With LPN (licens nurse who document.)	t 200 MG Give 1 tablet by the for AFIB. Awaiting m.) eMAR - Medication Metoprolol Succinate XL. the one time a day for HTN. Medication Administration cinate XL. Give 100 mg by the for HTN. Awaiting Medication Administration Give by mouth. Awaiting Medication Administration Give by mouth. Awaiting Medication Administration mg Give by mouth. Awaiting Mectronic medication 1 - Medication Administration mg Give by mouth. Awaiting Mectronic medication 25 mg Give 1 tablet by the for Heart Failure. Awaiting Mectronic medication Control of the form of t	F	580			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		OATE SURVEY COMPLETED
		495394	B. WING _			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	'	3072272310
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	Continued From pag	ge 15 ssion when the order is put in,	F 5	80		
	it [medications] com what staff did if a res available, LPN #1 st pharmacy. I can't re	es in that night." When asked sident's medications were not ated, "I usually call the member if I called them that if anyone else would be				
	a.m. with RN (register manager. When ask follows if a resident's	nducted on 6/22/18 at 9:19 ered nurse) #1, the unit ed about the process staff is medications are not ted, "They notify the doctor."				
	a.m. with LPN #2. W staff follows if the ma available, LPN #2 st of medication disper the doctor and see it	nducted on 6/22/18 at 9:53 //hen asked what process edications ordered were not ated, "If its not in the (name asing machine) I have to call f he wants to change the day and start it the next day."				
	staff member) #1, th	a.m. ASM (administrative e administrator and ASM #2, ng were made aware of the				
	NOTIFICATION" documents of the attending or on-(nurse practitioner), respectively.	c's policy titled, "PHYSICIAN cumented, "Policy: The eport changes in the guest's ess, exacerbation of existing into and incidents to the ctitioner, or physician the established Interact eate, not-immediate, or Definitions: Immediate: Notify call MD (medical doctor), NP or PA (physician's assistant). Non-Immediate: Notify the				

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AND DI AN OF CORRECTION IDENTIFICATION NUMBER:		I ` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495394	B. WING _			06/:	22/2018
	ROVIDER OR SUPPLIER		,	91	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE ON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	than the next work da attending or on-call M the next regular visit physician of a change Document the time at was notified, the physician of achange Tocument the time at was notified, the physician of distinct formation. 1. Amiodarone is a pagent that has been of distinct forms of drug information was obtain https://livertox.nih.gov. 2. Metoprolol is a care that is widely used in hypertension and and been linked to rare cainjury. This information https://livertox.nih.gov. 3. KEPPRA is indicate the treatment of partial and children 1 month epilepsy. This information the pilepsy. This information https://dailymed.nlm.rm?setid=3ca9df05-ast 1.	ID, NO (sic), or PA no later by. Routine: Notify the ID, NP, or PA no later than .Procedure: 1. Notify the in the guest's condition. 2. Ind date that the physician sician's response, and any the Progress Notes." In was obtained prior to exit. In was obtained from: In onset seizures in adults In onset seizures in adults	F	580			

PRINTED: 07/20/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495394	B. WING _				22/2018
	ROVIDER OR SUPPLIER			91	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE ON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	expansion, and lifesty information was obtain https://dailymed.nlm.rm?setid=4c3517f3-1c1 5. Oxybutynin chloridare a muscarinic antattreatment of overactivurge urinary incontine frequency. This informattps://dailymed.nlm.rm?setid=033a9242-b30 6. Spironolactone tabtreatment of NYHA Creduced ejection fractmanage edema, and hospitalization for heavas obtained from: https://dailymed.nlm.rm?setid=beaf74db-411 3. The facility staff faiwhen Resident #50's Resident #50 was add 1/6/14 and readmitted that included but were diabetes, atrial fibrillablood pressure. Resid (minimum data set) a assessment with an Adate) of 5/7/18. Resid being cognitively intak	g non-pharmacologic apport stockings), fluid alterations. This ned from: nih.gov/dailymed/drugInfo.cf a68-4ade-b5f1-c488a3a335c e extended-release tablets agonist indicated for the re bladder with symptoms of ence, urgency, and mation was obtained from: nih.gov/dailymed/drugInfo.cf bf2-49d5-8403-d07e991071 lets are indicated for lass III-IV heart failure and tion to increase survival,	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		OATE SURVEY COMPLETED
	495394	B. WING			C 06/22/2018
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF BON AIR			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	I	06/22/2016
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
received Humalog (1) following order was de "Humalog KwikPen Se Unit/ML (milliliter) (ins scale: If 141-180=4 units 181-220=6 units 221-260=8 units 261-300=10 units 301-350 = 12 units 351-400 =16 units 40 MD (medical doctor), meals and at bedtime Review of Resident # (medication administr on 4/6/18 at 11:30 a.n. There was no evidence notified of this low blo evidence that the nurs place to increase her #50's Humalog was d shift. Further review of Res report revealed that si percent of her lunch the Review of Resident # that on 4/6/18 at 4:37 sugar had risen to 80.	Status) exam. 50's April 2018 POS mary) revealed that she sliding scale insulin. The ocumented: olution Pen-Injector 100 ulin lispro) Inject per sliding 1 or greater 16 units and call subcutaneously before for DM (diabetes mellitus)." 50's April 2018 MAR ation record) revealed that n., her blood sugar was 50. be that the physician was od sugar. There was no se had put an intervention in blood sugar. Resident ocumented as held that ident #50's meal intake the had consumed 26-50 that day. 50's nursing notes revealed p.m., Resident #50's blood At 4:45 p.m., Resident pped down to 70 and then	F 58	0		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			DATE SURVEY COMPLETED
		495394	B. WING _			
	ROVIDER OR SUPPLIER	10000		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	<u> </u>	06/22/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580	notified at this time unresponsiveness of increase the blood sincrease the blood sincrease. At risk from the signs of complete sincrease	ence that the physician was of Resident #50's despite interventions to sugar. #50's diabetes care plan amented the following: "Blood for fluctuation blood sugars betes. Goal: Guest will be complications from fluctuation as mental status and document s/sx blications from fluctuating abnormal findings to p.m., an interview was a l (licensed practical nurse) #4, ed with Resident #50 on when asked what she bood sugar, LPN #4 stated that patient. When asked what oglycemic (2), LPN #4 stated, "When asked the nursing the would immediately give bring it up, recheck the blood esident closely, and then ugar again in thirty minutes. Would document these #4 stated, "Yes." LPN #4	F 5	80		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
		495394	B. WING			С
		495394	B. WING_		•	6/22/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	
THELAUE	RELS OF BON AIR			9101 BON AIR CROSSINGS DRIVE		
	tee or bonyant			BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 580	Continued From pa	age 20	F 5	580		
F 580	glucagon. LPN #4 standing order and physician to obtain was familiar with R that she worked wi of occasions. Whe Resident #50's blo 4/6/18 at 11:30 a.n could not remembe the initials on the N record) were hers, asked if the physic low blood sugar re 4/6/18, LPN #4 sta should have docur nursing note. LPN way if she had put #4 stated, "Maybe LPN #4 stated that she would stop and When asked how the would know what	astated that glucagon was not a lishe would have to call the an order. When asked if she tesident #50, LPN #4 stated if Resident #50 on a number on asked if she could recall od sugar reading being 50 on an., LPN #4 stated that she er that far back. When asked if MAR (medication administration LPN #4 stated, "Yes." When ian was notified regarding the ading of 50 at 11:30 a.m. on atted that she was not sure and mented that information in a #4 could not determine either an intervention in place. LPN the 50 was a miscoding?" It if a blood sugar was that low did call the MD (medical doctor). This writer and other nurses was done for Resident #50, but mean to tell me I recorded 50, and I didn't do anything?" It p.m., an interview was N #3. When asked what she sycemic, LPN #3 stated, D." When asked the process she were to have a resident level of below 60, LPN #3 uld provide the resident orange kers with peanut butter for ould check on them every 15 stated that if food interventions	F	580		
	order for glucagon she would still noti	vould notify the MD to obtain an and administer. LPN #3 stated fy the MD for any hypoglycemic tated, "It's something critical				

	OF DEFICIENCIES F CORRECTION			(X3) DATE SURVEY COMPLETED	
		495394	B. WING		C 06/22/2018
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 580	that happened to the that she would alway that were put into pla made aware in a nur nurses would know place for a low blood was notified if there clinical record, LPN have put it on the 24 that if the nurse did report than there was done. The 24-hour report f ASM (administrative (Director of Nursing) On 6/21/18 at approreport was presente box was completely On 6/21/18 at 1:56 pconducted with ASM ASM #3 could not re Resident #50's low be that she probably we monitor and maybe stated that a blood sconsidered hypoglyd she would first experecheck in an hour a ASM #3 that she wo here aware of any his stated that nursing sthey just didn't docur. On 6/22/18 at 12:02 administrator, ASM is a nursing store the country of	e resident." LPN #3 stated by document interventions ace and that the MD was ring note. When asked how if interventions were put into disugar or that the physician is no documentation in the #3 stated that the nurse may hour report. LPN #3 stated not document on the 24-hour is no was of knowing what for 4/6/18 was requested from staff member) #2, the DON but with the physician is no was of knowing what for 4/6/18. The 7-3 shift blank. D.m., an interview was a #3, the nurse practitioner. It is a stated being made aware of blood sugar. ASM #3 stated being made aware of blood sugar. ASM #3 stated that contains the glucagon. ASM #3 stated that contains the glucagon in the physician in the physicia	F 58		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495394	B. WING				22/2018
	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 0101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 001	22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page Operations, were made concerns.	e 22 de aware of the above	F	580			
	documents in part, the nurse will report chandule to illness, exacer or accidents and incide practitioner, or physice established interact penot-immediate, or round 1. Notify the physician condition. 2. Docume	n was provided by					
	lispro is a combinatio an intermediate-acting Insulin is used by peo- keep blood sugar level information was obtain Institutes of Health.	spro protamine and insulin n of a fast-acting insulin and g type of human insulin. ople with diabetes to help els under control. This ned from The National nih.gov/pubmedhealth/PMH etails.					
	blood sugar. Your boo enough energy. After glucose. If you eat mo needs, your muscles,	ans low blood glucose, or dy needs glucose to have you eat, your blood absorbs ore sugar than your body and liver store the extra. ar begins to fall, a hormone ase glucose. In most					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495394	B. WING _			C / 22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	have hypoglycemia, a dangerously low. Sign Shakiness, Dizziness speaking, Feeling and with diabetes, hypogly of diabetes medicines something with carbo information was obtain Institutes of Health. https://medlineplus.go. Hypoglycemia, also clow blood sugar, occur your blood drops be people with diabetes, milligrams per decilite information was obtain Institutes of Health. https://www.niddk.nih	ood sugar. If it doesn't, you and your blood sugar can be ns include Hunger, , Confusion, Difficulty kious or weak. In people ycemia is often a side effect	F 5	580		
F 583 SS=D	used to treat severe h sugar) in diabetes par obtained from The Na https://www.ncbi.nlm. T0010481/?report=de Personal Privacy/Con CFR(s): 483.10(h)(1)- §483.10(h) Privacy ar The resident has a rig	offidentiality of Records officertiality. The confidentiality. The personal privacy and or her personal and medical	F 5	583		8/3/18

PRINTED: 07/20/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
		495394	B. WING _		C 06/3:	C 06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	00/2/	2/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 583	telephone communica and meetings of familithis does not require private room for each §483.10(h)(2) The fact residents right to persight to privacy in his written, and electronic the right to send and mail and other letters materials delivered to including those delivered to one describe the state Lo to personal and mediprovided at §483.70(if federal or state laws. (ii) The facility must a Office of the State Lo to examine a resident administrative recordilaw. This REQUIREMENT by: Based on observation interview and facility of determined that the facility of the facility staff failed one of 32 residents in Resident # 32. The facility staff failed.	dical treatment, written and ations, personal care, visits, y and resident groups, but the facility to provide a resident. cility must respect the sonal privacy, including the or her oral (that is, spoken), communications, including promptly receive unopened, packages and other the facility for the resident, ared through a means other sident has a right to secure onal and medical records. The right to refuse the release cal records except as (2) or other applicable. Illow representatives of the ing-Term Care Ombudsman its medical, social, and is in accordance with State. The is not met as evidenced on, resident interview, staff document review, it was accility staff failed to maintain uring incontinence care for	F 5	Resident #32 is receiving inconting care daily and privacy is being processed and privacy incontinence care has be performed. Licensed Nursing Staff re-educated DON or Designee regarding ensurprivacy curtains are used when privacy curtains are use	ovided. Its een ed by ring that		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495394	B. WING	B. WING		C 06/22/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	22/2010	
THE LAUF	RELS OF BON AIR			0101 BON AIR CROSSINGS DRIVE			
				BON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 583	Continued From page	e 25	F 583				
	The findings included	:		care to residents.			
	08/12/16 with diagnosmot limited to Alzheim and dysphagia (3). On 06/19/18 at approtent initial tour of the fire Resident # 32's and Fooducted. During the door was closed. When the door, staff inside the room, Resident # B-side of the room, reprivacy curtain betwee beds was pulled approfrom the wall exposin waist to her feet. Fur Resident # 32 was ur her feet exposing the wearing. Resident # were present in the roobservation on the Awere observed crowd closed privacy curtain	side of the room. They led behind the partially n. recent MDS (minimum data		DON/Designee will conduct quality monitoring for the use of privacy curtar during resident care five times a week weekly x4 and then monthly, PRN and indicated. Findings to be communicated to the Q committee monthly and as indicated. Quality monitoring schedules will be modified as indicated based on finding	x1, ⊢as A		
	(assessment reference Resident # 32 as sco- interview for mental s - 15, 0 (zero) - being cognition for making of 32 was coded as requ- of one staff member f	ce date) of 04/19/18, coded ring a 0 (zero) on the brief tatus (BIMS) of a score of 0					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495394	B. WING		C 06/22/2018
	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF BON AIR			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 583	conducted with CNA 1. When asked to do maintaining a reside incontinence care to "During care I keep body I'm working on gown if they are west the reasonable persexposed like, Residereceiving personal/in stated, "They would no one would want to who is not taking ca modesty would be well Attempts were made survey to interview I and visitor who was observation of Reside attempts were unsu unavailability of Reside Responsibilities" do confidentiality. The personal privacy and personal Privacy. Fersonal Privacy. Fersonal Privacy. Fersonal Privacy. Fersonal Privacy and personal meetings of fam this does not require private room for each On 06/22/18 at appre (administrative staff)	A (certified nursing assistant) # lescribe the procedure for ent's dignity while providing to a resident CNA # 1 stated, the area of the resident's covered with a sheet or the aring one." When asked how con would feel if they were ent # 32 was observed when incontinence care, CNA # 1 in't feel comfortable because to be exposed to someone are of them and their sense of iolated." de during the days of the Resident # 32's roommate present during the dent # 32 on 06/19/18. The cocessful due to the dident # 32's roommate and ent Rights & Facility cumented, "(h) Privacy and resident has a right to d confidentiality of his or her all records. (1) Scope of Personal privacy includes dedical treatment, written and cations, personal care, visits, hily and resident groups, but the facility to provide a	F 58	33	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
		405204	B. WING			С	
	ROVIDER OR SUPPLIER	495394	D. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	<u>l</u>	06/	22/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE		(X5) COMPLETION DATE
F 622 SS=E	References: (1) A brain disorder the person's ability to car information was obtain https://www.nlm.nih.gsease.html. (2) Fear. This information website: https://www.nlm.nih.gsummary. (3) A swallowing diso obtained from the wehttps://www.nlm.nih.gsorders.html. Transfer and Discharg. CFR(s): 483.15(c)(1) Facility (i) The facility must peremain in the facility, discharge the resident (A) The transfer or discresident's welfare and cannot be met in the (B) The transfer or discresident's the resident's because the resident's because the resident's because the resident's welfare and cannot be met in the (B) The transfer or discresident's welfare and cannot be met in the season of the resident's welfare and cannot be met in the season of the resident's welfare and cannot be met in the season of the resident's welfare and cannot be met in the season of the resident's welfare and cannot be resident's welfare and cannot be met in the season of the resident's welfare and cannot be met in the season of the resident's welfare and cannot be resident's	nat seriously affects a rry out daily activities) This ined from the website: gov/medlineplus/alzheimersdi ation was obtained from the gov/medlineplus/anxiety.html arder. This information was bsite: gov/medlineplus/swallowingdi age Requirements (i)(ii)(2)(i)-(iii) and discharge- arequirements- ermit each resident to and not transfer or and from the facility unless- scharge is necessary for the d the resident's needs		583 622			8/3/18
	endangered due to the status of the resident	viduals in the facility is ne clinical or behavioral					

PRINTED: 07/20/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495394	B. WING _			C 06/22/2018	
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF BON AIR			91	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE ON AIR, VA 23235	1 001	22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	appropriate notice, to under Medicare or Medicaresident refuses to paresident who become admission to a facility resident only allowable or (F) The facility ceases (ii) The facility may not resident while the apply 431.230 of this charge notice from 431.220(a)(3) of this charge or transfer or safety of the reside facility. The facility methat failure to transfer when the facility transfer or safety of the resident under any of in paragraphs (c)(1)(i) section, the facility medical record and a communicated to the institution or provider. (i) Documentation in the must include:	failed, after reasonable and pay for (or to have paid edicaid) a stay at the facility. If the resident does not paperwork for third party hird party, including the decision of the paperwork for third party hird party, including the decision of the claim and the pay for his or her stay. For a seligible for Medicaid after the facility may charge a decharges under Medicaid; the facility may charge the decision of the facility pursuant to enter, when a resident ght to appeal a transfer or the facility pursuant to enter, unless the failure to would endanger the health and or other individuals in the decision of the decision. See the circumstances at the circumstances specified the decision of the resident's performation is receiving health care	F	522			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495394	B. WING _		C 06/22/2018		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		5/22/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 622	(B) In the case of parsection, the specific robe met, facility attempreeds, and the service facility to meet the neth (ii) The documentation (2)(i) of this section method (B) A physician when necessary under parathis section. (iii) Information provide must include a minimer (A) Contact information (C) Advance Directiver (D) All special instruction (C) Advance Directiver (D) All special instruction (F) All other necessary composing care, as approposition (F) All other necessary of the resident's consistent with §483. any other documental a safe and effective to the transfer for five of 32 method (2) in the receiving provider transfer for five of 32	agraph (c)(1)(i)(A) of this esident need(s) that cannot obts to meet the resident e available at the receiving ed(s). In required by paragraph (c) thust be made by-visician when transfer or ry under paragraph (c) (1) on; and transfer or discharge is agraph (c)(1)(i)(C) or (D) of ded to the receiving provider turn of the following: on of the practitioner are of the resident. Intative information including the information including a discharge summary, 21(c)(2) as applicable, and tion, as applicable, to ensure the instance of the resident of care. It is not met as evidenced the information was provided to a for a facility-initiated residents in the survey of the sident in the survey of the facility and #64.	F 6	Resident #46 returned to the fanegative outcome has occurred practice. Resident #50 returned facility. No negative outcome hoccurred from this practice. Rereturned to the facility. No negative outcome has occurred from this Resident #110 did not return to No negative outcome has occur	from this d to the as sident #39 ative practice. the facility.		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495394	B. WING			C 06/22/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	, 0	3/22/2010
				9.	101 BON AIR CROSSINGS DRIVE		
THE LAURELS OF BON AIR				В	ON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	Continued From page	∋ 30	F	622			
	evidence that all the i	equired information was			this practice. Resident #64 returned to		
	provided to the receiv	ving provider for a			the facility. No negative outcome has		
	facility-initiated transf	er on 6/8/18.			occurred from this practice.		
	2. For Resident #50,	-			All residents have the potential to be		
	evidence that all requ				affected.		
	provided to the receiv	- :			Licensed Nurses to be educated by		
	racility-initiated transf	er on 3/9/18 and 4/6/18.			DON/Designee regarding providing information to the receiving provider for		
	3 For Resident #30	the facility staff failed to			facility-initiated transfer.	а	
	evidence that all requ				lacinty-initiated transfer.		
		tal upon a transfer to the			DON/Designee will conduct quality		
	hospital on 4/19/18.				monitoring of facility initiated transfers,	5x	
					a week x1 week, weekly x4 weeks and		
	4. For Resident #110), the facility staff failed to			then monthly, PRN and as indicated.		
	evidence that all requ	ired information was					
	provided to the hospi	tal upon a transfer to the			Findings to be communicated to the Q/	4	
	hospital on 3/21/18.				committee monthly and as indicated. Quality monitoring schedules will be		
	5. For Resident # 64,	the facility staff failed to			modified as indicated based on finding	S.	
		ired documentation and					
	information was provi	ded to the receiving provider					
	for a facility-initiated t	ransfer on 06/12/18.					
	The findings include:						
		admitted to the facility on					
		d on 6/13/18 with diagnoses					
		e not limited to muscle					
	i i	ntion, post stroke, acquired					
		cified parts of digestive tract					
) and jejunostomy tube (2),					
		and diabetes. Resident DS (minimum data set)					
) day scheduled assessment					
		ment reference date) of					
	5/9/18. Resident #46						
		ie ability to make daily					
		out of possible 15 on the					

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495394	B. WING			C 06/22/2018	
	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	Review of Resident # that he had gone out A SBAR (Situation, Boundaries) Recommendation) for documented in part, to Evaluation: Decrease consciousnessResp. ProductiveAbdomin pain/tenderness/dister abdomenSummarize evaluation: Please evaluation: Pleas	for Mental Status) exam. 46's clinical record revealed to the hospital on 6/8/18. ackground, Assessment and rm dated 6/8/18, he following: "Mental Status ed level of Diratory Evaluation: Cough, hall Evaluation: Abdominal ended everyour observations and raluate for possible abscess mostomy tube) site, fever, smelling drainage. Primary d: (Name of NP (nurse 8/18 at 11:30 a.m., Frimary Clinicians (if any): never room) for Evaluation." 19 Home to Hospital Transfer ridenced Resident #46's fithe practitioner responsible sident, resident ation including contact directive information and all representations for ongoing ce that Resident #46's plan or comprehensive care with the resident at the time 10 m., an interview was compared to the transfer of the practical nurse (if any): not compared to the transfer of the practical nurse (if any): not compared to the transfer of the practical nurse (if any): not compared to the transfer of the practical nurse (if any): not compared to the transfer of the practical nurse (if any): not compared to the transfer of the practical nurse (if any): not compared to the transfer of the practical nurse (if any): not compared to	F	622			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G	· ,	(X3) DATE SURVEY COMPLETED	
		495394	B. WING			C 06/22/2018	
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF BON AIR				STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		1012212010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 622	(RP/MD [responsible When asked if the Coplan) or comprehens sent with the resider #1 stated that the cocare plan goals were On 6/22/18 at 12:02 administrator, ASM Nursing), and ASM Operations, were maconcerns. The facility policy titl Hospital," document "Following a physicia will complete the appan acute care setting	esident's contact information e party/ medical doctor]). CP (comprehensive care sive care plan goals were at at the time of transfer, LPN emprehensive care plan or e not sent with the resident. p.m., ASM #1, the #2, the DON (Director of #4, the Regional Director of ade aware of the above ed, "Transferring Guest to the s in part, the following: an's order, nursing personnel propriate forms for transfer to g, thus ensuring continuity of	F 6:	22			
	change in a guests of related to a planned etcComplete the famost recent monthly guest's Medication A and the guest's adva (1) Gastronomy- A pgastronomy tube cally hydration and medicatomach. Patients wunable to swallow sa aspiration of food, dlungs. This informat National Institutes of https://www.ncbi.nlm (2) Jejunostomy allo	acility transfer form, copy the physician's order sheet, the administration Record (MAR), anced directive." Dercutaneous endoscopic in be used to deliver nutrition, sines directly into the patient's ill require a tube if they are afely, putting them at risk of rink and medicines into their tion was obtained from The					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTIO	N	(X3) DATE SURVEY COMPLETED	
		495394	B. WING _	B. WING		C 06/22/2018	
	ROVIDER OR SUPPLIER				S, CITY, STATE, ZIP CODE ROSSINGS DRIVE 23235	1 00	22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD E S-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 622		ational Institutes of Health. ov/publications/dictionaries/c	F	22			
	2. For Resident #50, evidence that all requ provided to the receiv facility-initiated transf	ired information was					
	1/6/14 and readmitted that included but were diabetes, atrial fibrillated blood pressure. Resident manner (minimum data set) at assessment with an Adate) of 5/7/18. Resident cognitively inta	mitted to the facility on d on 4/13/18 with diagnoses e not limited to type two tion, heart failure, and high dent #50's most recent MDS ssessment was an annual ARD (assessment reference dent #50 was coded as ct in the ability to make daily out of 15 on the BIMS (Brief Status) Exam.					
	that she was transfer due to a fall. The follo "Found on floor next 4:05 p.m. No neuro of RR (respirations) is 2 134/92. Unable to ex (complained) pain in and order received to Daughter (Name of do requests (Name of hos [emergency medical	250's clinical record revealed red to the hospital on 3/9/18 owing was documented: to bed on R (right) side at hanges noted. Pulse is 124 4 BP (blood pressure) is stend R leg in bed, c/o hip area. Physician notified a send guest out at 4:10 p.m. aughter), notified, and ospital). Transported at this pital) via (Name of EMT transport] Service). "					
	following: "Interfacility	r transfer sheet, copy of code sheet and face sheet					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495394	B. WING _			C 06/22/2018	
	ROVIDER OR SUPPLIER	J		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	· · · · · · · · · · · · · · · · · · ·	00/22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 622	(Name of hospital)." There was no evider comprehensive care the resident at the tir Review of Resident at that she arrived backwith diagnoses of a I repair. Further review of Rerevealed she was trathe second time on a documented: "Blood taken in R (right) har (certified nursing ass (vital signs) at 5 pm with VS and FSBS (15:05 p.m. Cool H20 to attempt to get vert success. At 5:10 p.r. Glucagon (1) given a station per staff. Pull rate) 16, BP (blood p. Attempt made to call portable phone in roon on answer, EMTs (el technicians) arrived verbally with vital sig written. DON (Directime with information physician's emergen physician) at this tim	ace that Resident #50's plan goals were sent with me of transfer on 3/9/18. #50's nursing notes revealed to the facility on 3/13/18 hip fracture and post surgical sident #50's clinical record ansferred to the hospital for 1/6/18. The following was Sugar at 4:45 pm 70 and and. Guest is drowsy. CNA sistant) enters room for VS and guest is unresponsive fasting blood sugar) of 22 at (water) and washcloths used bal response without m., blood sugar at 32 with and 911 called from nurses lee is 102, RR (respiratory pressure) 134/82 manually. It daughter from guests om at this time unsuccessful, mergency medical at 5:15 p.m. with report given and blood glucose results tor of Nursing) texted at this is and message left on on-call cy number for (Name or e."	F 6	22			
	information was sent time of transfer on 4	t with Resident #50 at the 6/18:					

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	C 6/22/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	6/22/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
THE LAURELS OF BON AIR 9101 BON AIR CROSSINGS DRIVE	
BON AIR, VA 23235	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622 Continued From page 35	
1) Contact information of the practitioner responsible for the care of the resident. 2) Resident representative information including contact information 3) Advance Directive information 4) All special instructions or precautions for ongoing care, as appropriate. 5) Comprehensive care plan goals Further review of Resident #50's clinical record revealed that Resident #50 returned to the facility on 4/13/18. The hospital physician documented the following: "Hypoglycemia (2): etiology is unclear. I was initially concerned about a medication error but her hypoglycemia was so profound (down in the 20s on admission and still dipping into the 20s on a D 10 (10 % Dextrose (sugar) drip and persisted for 3 days in the face of dextrose (sugar) boluses, dextrose IV (intravenous) continuous, initialisions and eating." Further review of Resident #50's hospital records revealed that she also had a diagnosis of a UTI (urinary tract infection). On 6/22/18 at 9:20 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked what information was on the transfer form, LPN #1 stated everything from the assessment to the resident's contact information (RP/MD) [responsible party/ medical doctorf). When asked if the CCP (comprehensive care plan or comprehensive care plan goals were sent with the resident at the time of transfer, LPN #1 stated that the comprehensive care plan or care plan goals were not sent with the resident.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED		
		495394	B. WING _		0.0	C 6/ 22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 622	Nursing), and ASM: Operations, were monconcerns. A transfe second hospitalization provided.	#2, the DON (Director of #4, the Regional Director of ade aware of the above r sheet for Resident #50's on on 4/6/18 could not be	F 6	22			
	used to treat severe sugar) in diabetes p obtained from The N	on is an emergency medicine hypoglycemia (low blood atients. This information was lational Institutes of Health. n.nih.gov/pubmedhealth/PMH details.					
	blood sugar. Your be enough energy. After glucose. If you eat meeds, your muscles. When your blood su tells your liver to reference, this raises be have hypoglycemia, dangerously low. Signakiness, Dizzines speaking, Feeling an with diabetes, hypogof diabetes medicine something with carbinformation was obtainstitutes of Health. https://medlineplus.go	s, Confusion, Difficulty nxious or weak. In people glycemia is often a side effect es. Eating or drinking ohydrates can help. This ained from The National gov/hypoglycemia.html.					
	low blood sugar, occ in your blood drops people with diabetes	called low blood glucose or curs when the level of glucose below normal. For many s, that means a level of 70 ter (mg/dL) or less. This					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495394	B. WING	B WING		C 06/22/2018	
	ROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 001	22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	Institutes of Health. https://www.niddk.nih etes/overview/preven cose-hypoglycemia. 3. For Resident #39, evidence that all requipment of the hospital on 4/19/18. Resident #39 was ad 6/13/17 and readmitter hospitalization, with the limited to stroke, hem disease, diabetes, an prostatic hyperplasia, stenosis, high blood palcohol abuse, and afrecent MDS (Minimur significant change as (Assessment Referencesident was coded a impaired in ability to resident went to the hof the nurse's notes fawhen the resident went to the hof the nurse of the supposed to write a number of the clinical resident is sent to the supposed to write a number of the clinical resident is sent to the supposed to write a number of the clinical review of the	ned from The National .gov/health-information/diab ting-problems/low-blood-glu the facility staff failed to ired information was tal upon a transfer to the mitted to the facility on ed on 4/26/18 after a brief ne diagnoses of but not iplegia, Parkinson's xiety disorder, benign dementia, dysphagia, spinal pressure, osteoarthritis, trial fibrillation. The most m Data Set) was a sessment with an ARD nce Date) of 5/4/18. The s severely cognitively make daily life decisions. al record revealed that the pospital on 4/19/18. A review failed to reveal any date for not to the hospital. m., in an interview with RN e), she stated that when a e hospital, nursing is note why someone went to iplete the "Interact" form.	F	622			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
	495394	B. WING			C 6/22/2018	
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF BON AIR			STREET ADDRESS, CITY, STATE, ZIP 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		0/22/2010	
PREFIX (EACH DE	MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
sent to and se (medical doctor Clinical Inform Functional State Devices and Tallergies, Risk Nursing Home Report called linformation, Social Issues, at Time of Transent Tallergies, at Time Tallergie	ographic information, where being nt from. RP name and number, MD or) name and number, Code Status, ation, Usual Mental Status, Usual tus, Additional Clinical Information, reatments, Isolation Precautions, Alerts, Personal Belongings Sent, ability to accept patient back, by and to, Nursing Home contact ocial Worker, Family and Other Behavioral Issues, Primary Goals and/or Medical Therapy with ing home, 2. Chronic long-term ive or end-of-life care, 4. Receiving 5. Other), Treatments and et, Skin/Wound Care, Physical Therapy, ADLs status,	F 63	22			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED		
		495394	B. WING			C)6/22/2018		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		06/22/2016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 622	findings. No further the end of the surve	sing) were made aware of the information was provided by	F 62	22				
	evidence that all red	quired information was poital upon a transfer to the						
	3/14/18 and dischardiagnoses of but no chronic thrombosis, pressure ulcer, dysplasorder, benign prochronic obstructive recent MDS (Minim admission/5-day as (Assessment References)	admitted to the facility on reged on 3/21/18 with the st limited to respiratory failure, alcohol abuse, cervicalgia, chagia, schizoaffective estatic hyperplasia, and pulmonary disease. The most sum Data Set) was an sessment with an ARD ence Date) of 3/21/18. The ste due to the resident leaving ion of the MDS.						
	resident went to the resident did not retu 3/21/18 at 4:00 a.m first round at 1230 a elevated and had at thru his mouth. not from out his mouth Guest did not responsive were rolled to Fingernails were coupper bases were fit (temperature), 110 168/88 (blood press	cal record revealed that the hospital on 3/21/18. The Irn. A nurse's note dated, documented, "Noted on the a.m., guest HOB (head of bed) bnormal breathing, breathing ed yellow drainage coming on to a towel on his chest. and to no {sic} stimli {sic}. the back of his head. Id and blue. Lung sounds to ull. VS (vital signs) 98.9 (pulse), 24 (respirations), sure), unable to obtain a pox ding [reading of oxygen DON/RP (medical						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495394	B. WING			C 6/22/2018
	RELS OF BON AIR			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	, CITY, STATE, ZIP CODE OSSINGS DRIVE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 622	doctor/director of nu notified w/N.O. (with (name of hospital) to (treat), noted and re at at {sic} 1240a.m Medical Technician) carried guest out via Further review of the reveal any document to or provided to the facility-initiated trans On 6/21/18 at 4:35 p #1 (Registered Nurs resident is sent to the supposed to write a the hospital, and cor A review of a copy of Hospital Transfer Foused by the facility revidence that either or the required data, the hospital with the On 6/22/18 at 10:02 #1, regarding the informal transferred to the hot transfer form." When included on the transassessment." When comprehensive care sent with residents, On 6/22/18 at 12:30 Staff Member, the A	rsing/responsible party) new order) send guest to o eval (evaluate) and tx ceived. Called 911 dispatch Several EMT'S (Emergency arrived at 1245 a.m., and stretcher." e clinical record failed to tation of any information sent hospital for the above efer. o.m., in an interview with RN e), she stated that when a e hospital, nursing is note why someone went to mplete the "Interact" form. of the "Nursing Home to orm" and the "Interact" form evealed there was no the form, or any similar form, was completed and sent to	F 62	22		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495394	B. WING	B. WING		C 06/22/2018	
	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 001	22/2010
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	evidence that any tra documentation was or resident on 3/21/18. No further information the survey. 5. For Resident # 64, evidence that all requinformation was provifor a facility-initiated to Resident # 64 was ac 02/14/18 with a readr diagnoses that including malignant neoplasm of gastroesophageal refobstructive pulmonar (5) and benign prostated to see the following up from general seeds as the seed of the following up from president # 64 as soo interview for mental seeds as the following up from president guest to (Name of Horn RP (responsible party wanted to transport guest to the following up from green to the following up from president to transport guest guest transport guest to transport guest transport guest transpor	was not able to locate any nsfer paperwork and ompleted and sent with the n was provided by the end of the facility staff failed to lired documentation and ded to the receiving provider ransfer on 06/12/18. Idmitted to the facility on mission of 03/13/18 with ed but were not limited to (1) of the larynx (2), lux disease (3), chronic y disease (4), tracheostomy tic hyperplasia (6). recent MDS (minimum data assment with an ARD ce date) of 05/18/18, coded	F	622			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		' '	(X3) DATE SURVEY COMPLETED		
	495394	B. WING			C 06/22/2018		
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		1 00/22/2010		
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE		
The nurse's "Progred dated 06/13/18 doctop.m.) Guest arrived Hospital) accompar Guest made comfor CNA (certified nursi" On 06/22/18 at 10:0 conducted with RN asked describe what to the receiving facit transferred RN # 1 sare notified by phone by nursing at the tin transfer form is comprehensive care are sent with the restransfer, RN # 1 states Review of the facilit "Inter-Facility Conting Resident # 64 failed comprehensive care transfer paperwork. Review of Resident evidence the receiv Resident # 64's conducted to the comprehensive care transfer paperwork.	ess Notes" for Resident # 64 umented in part, "19:313 (7:13 via w/c from (Name of nied by RP (Name of RP). rtable in room by writer and ng assistant), RP at bedside 00 a.m., an interview was (registered nurse) # 1. When at documentation is provided lity when a resident is stated, "The RP and physician ne, a bed hold policy is offered ne of the transfer, and a npleted and sent with the ked if a copy of the resident's e plan or their care plan goals sident at the time of the ted, "No." y's transfer form entitled nuity of Care Report" for to evidence the resident's e plan goals as part of the # 64's clinical record failed to ing facility received a copy of nprehensive care plan goals. roximately 12:00 p.m., ASM	F 623					
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF The nurse's "Progred dated 06/13/18 doc p.m.) Guest arrived Hospital) accompar Guest made comfor CNA (certified nursi" On 06/22/18 at 10:0 conducted with RN asked describe what to the receiving facit transferred RN # 1 are notified by phor by nursing at the tin transfer form is comresident." When as comprehensive care are sent with the restransfer, RN # 1 states Review of the facilit "Inter-Facility Contin Resident # 64 failed comprehensive care transfer paperwork. Review of Resident evidence the receive Resident # 64's continuation of the facilit resident # 64's continuation of the facility of th	RELS OF BON AIR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 42 The nurse's "Progress Notes" for Resident # 64 dated 06/13/18 documented in part, "19:313 (7:13 p.m.) Guest arrived via w/c from (Name of Hospital) accompanied by RP (Name of RP). Guest made comfortable in room by writer and CNA (certified nursing assistant), RP at bedside" On 06/22/18 at 10:00 a.m., an interview was conducted with RN (registered nurse) # 1. When asked describe what documentation is provided to the receiving facility when a resident is transferred RN # 1 stated, "The RP and physician are notified by phone, a bed hold policy is offered by nursing at the time of the transfer, and a transfer form is completed and sent with the resident." When asked if a copy of the resident's comprehensive care plan or their care plan goals are sent with the resident at the time of the transfer, RN # 1 stated, "No." Review of the facility's transfer form entitled "Inter-Facility Continuity of Care Report" for Resident # 64 failed to evidence the resident's comprehensive care plan goals as part of the transfer paperwork. Review of Resident # 64's clinical record failed to evidence the receiving facility received a copy of Resident # 64's comprehensive care plan goals. On 06/22/18 at approximately 12:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of	A BUILDING 495394 A BUILDING ROVIDER OR SUPPLIER RELS OF BON AIR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 42 The nurse's "Progress Notes" for Resident # 64 dated 06/13/18 documented in part, "19:313 (7:13 p.m.) Guest arrived via w/c from (Name of Hospital) accompanied by RP (Name of RP). Guest made comfortable in room by writer and CNA (certified nursing assistant), RP at bedside" On 06/22/18 at 10:00 a.m., an interview was conducted with RN (registered nurse) # 1. 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On 06/22/18 at approximately 12:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of	RELS OF BON AIR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) Continued From page 42 The nurse's "Progress Notes" for Resident # 64 adated 06/13/18 documented in part, "19:313 (7:13 p.m.) Guest arrived via wic from (Name of Hospital) accompanied by RP (Name of RP). Guest made comfortable in room by writer and CNA (certified nursing assistant), RP at bedside" On 06/22/18 at 10:00 a.m., an interview was conducted with RN (registered nurse) # 1. When asked describe what documentation is provided to the receiving facility when a resident is transfer red RN # 1 stated, "The RP and physician are notified by phone, a bed hold policy is offered by nursing at the time of the transfer, and a transfer form is completed and sent with the resident." 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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495394	B. WING			C 6/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		0/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 622	of cancerous cells to other sites in the invade nearby (local Malignant cells tend growth and DO NO in their genetic make resistant to treatmed detectable traces of destroyed. This inforthe website: https://medlineplus. (2) The larynx, or voor and performs sever body. The larynx is breathing, and voice produced when the vocal cords causes sound waves in the The pitch of sound in of tension on the voor was obtained from the https://medlineplus.htm. (3) Stomach content the esophagus and was obtained from the https://www.nlm.nih (4) Disease that macan lead to shortnes was obtained from the https://www.nlm.nih (5) A surgical proce	nancy" refers to the presence hat have the ability to spread body (metastasize) or to lly) and destroy tissues. It to have fast; uncontrolled I die normally due to changes eup. Malignant cells that are not may return after all them have been removed or remation was obtained from gov/ency/article/002253.htm. Dice box, is located in the neck all important functions in the involved in swallowing, are production. Sound is air which passes through the them to vibrate and create pharynx, nose and mouth. Is determined by the amount cal folds. This information he website: gov/ency/imagepages/19708. Its to leak back, or reflux, into irritate it. This information he website: gov/medlineplus/gerd.html. I kes it difficult to breath that as of breath). This information	F 62	22		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
			7.1.56.1.51.1.0			(С
		495394	B. WING_			06/	22/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 9101 BON AIR CROSSINGS D			
THE LAUF	RELS OF BON AIR			BON AIR, VA 23235	NATE .		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD B ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 622 F 623 SS=E	tube is most often pla provide an airway and the lungs. This tube is or trach tube. This in the website: https://medlineplus.go (6) An enlarged prost obtained from the wel https://www.nlm.nih.g statebph.html.	ced through this opening to d to remove secretions from so called a tracheostomy tube formation was obtained from ov/ency/article/002955.htm. ate. This information was obsite: ov/medlineplus/enlargedpro Before Transfer/Discharge (6)(8) before transfer. fers or discharges a	F				8/3/18
	(i) Notify the resident representative(s) of the the reasons for the manguage and manner facility must send a corepresentative of the Long-Term Care Ombour (ii) Record the reason discharge in the residuaccordance with para and (iii) Include in the notiparagraph (c)(5) of the \$483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, it discharge required unmade by the facility at resident is transferred.	and the resident's ne transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the State oudsman. us for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or ider this section must be t least 30 days before the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION 3	, ,	(X3) DATE SURVEY COMPLETED		
		495394	B. WING			C 06/22/2018	
	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF BON AIR			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 623	be endangered und this section; (B) The health of incompletion be endangered, und this section; (C) The resident's hallow a more immedunder paragraph (c) (D) An immediate trequired by the resident has not days. §483.15(c)(5) Contentice specified in pure paragraph (c) (i) The reason for the foliation of the fol	scharge when- dividuals in the facility would er paragraph (c)(1)(i)(C) of dividuals in the facility would der paragraph (c)(1)(i)(D) of lealth improves sufficiently to diate transfer or discharge, (1)(1)(i)(B) of this section; ansfer or discharge is dent's urgent medical needs, (1)(1)(i)(A) of this section; or lot resided in the facility for 30 ents of the notice. The written laragraph (c)(3) of this section lowing: ransfer or discharge; the of transfer or discharge; which the resident is larged; he resident's appeal rights, address (mailing and email), ber of the entity which lests; and information on how form and assistance in land submitting the appeal less (mailing and email) and of the Office of the State	F 62	23			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495394	B. WING		C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00/22/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERS) CROSS-REFERENCED TO THE APPRODE (PROVIDER OF THE APPRODE)	JLD BE COMPLETION
F 623	C of the Developme and Bill of Rights Accodified at 42 U.S.C (vii) For nursing facidisorder or related cemail address and tagency responsible advocacy of individuestablished under the for Mentally III Indivisional Indivisional III Indivisional Indivisional III Indivisional III Indivisional III Indivisional III Indivisional III Indivisional Indivisional III Indi	polities established under Part Intal Disabilities Assistance at of 2000 (Pub. L. 106-402, 1. 15001 et seq.); and lity residents with a mental lisabilities, the mailing and elephone number of the for the protection and als with a mental disorder are Protection and Advocacy duals Act. The ges to the notice. The notice changes prior to are of discharge, the facility ipients of the notice as soon the updated information The in advance of facility closure of closure, the individual who is the facility must provide are Ombudsman, residents of the are Ombudsman, residents of the are Ombudsman, residents of the are ombudsman, as required at § The in of met as evidenced are of the are of	F 62	The responsible party for resident aware of resident's transfer to the hospital. The responsible party for resident ware of resident's transfer to the hospital transfer to the hospital. The Ombudsman has been made of #39s discharge to the hospital. The responsible party for resident to the hospital.	#50 is ospital. aware

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495394	B. WING		C 06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	7 33/22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	D BE COMPLETION	
F 623	1. For Resident #46 written notification of transfer to the hosp. 2. For Resident #50 written notification of transfer to the hosp. 3. For Resident #3 evidence that the resombudsman was p of the hospital trans. 4. For Resident #1 evidence that the reswith written notifica 3/21/18. 5. For Resident #6 provide written notifical motifical written notifical motifical series.	6, facility staff failed to provide to the responsible party for a sital on 6/8/18. 10, facility staff failed to provide to the responsible party for a sital on 3/9/18 and 4/6/18. 10, the facility staff failed to responsible party and rovided with written notification after of 4/19/18. 10, the facility staff failed to responsible party was provided tion of the hospital transfer of 4/19/18, and of a facility initiated	F 623	aware of resident's transfer to the hospital. The responsible party for resident #6 aware of resident's transfer to the hospital. All residents have the potential to be affected. Licensed Nursing Staff to be educate DON/designee regarding providing worth to the responsible party was residents are transferred out of the first The Administrator will be in-serviced assure all quests who discharge from facility are listed on the report sent to Ombudsman. DON/Designee during morning clinic meeting to conduct quality monitorin transfers out of the facility to ensure written notification is provided to the responsible party 5x week x1 week, weekly x4 weeks, monthly and then	ed by written when acility. to n the o the g of then PRN.	
	6/9/14 and readmit that included but we weakness, urine re absence of other sy with a gastronomy high blood pressure #46's most recent Nassessment was a with an ARD (asses 5/9/18. Resident # cognitively intact in	e: s admitted to the facility on ted on 6/13/18 with diagnoses ere not limited to muscle tention, post stroke, acquired pecified parts of digestive tract (1) and jejunostomy tube (2), e, and diabetes. Resident MDS (minimum data set) 60 day scheduled assessment esment reference date) of 46 was coded as being the ability to make daily 2 out of possible 15 on the		The Administrator will review the list discharges sent to the Ombudsman assure all residents are listed. Findings to be communicated to the committee monthly and as indicated Quality monitoring schedules modified based on findings.	to QA	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495394	B. WING	B. WING		C 06/22/2018	
NAME OF P	ROVIDER OR SUPPLIER	40004	1		STREET ADDRESS, CITY, STATE, ZIP CODE	06/	22/2018
WAWL OF TH	TOVIDER OR OUT FEILER				9101 BON AIR CROSSINGS DRIVE		
THE LAUF	RELS OF BON AIR				BON AIR, VA 23235		
(VA) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page	<u>.</u> 48	F	623	3		
. 020	. •	for Mental Status) exam.		02.			
		46's clinical record revealed to the hospital on 6/8/18.					
	A SBAR (Situation, Ba	ackground, Assessment and rm dated 6/8/18,					
	-	he following: "Mental Status					
	ProductiveAbdomin	oiratory Evaluation: Cough, al Evaluation: Abdominal					
	pain/tenderness/diste	nded e your observations and					
		aluate for possible abscess					
		nostomy tube) site, fever,					
		smelling drainage. Primary					
		d: (Name of NP (nurse					
	practitioner) Date: 6/8	3/18 at 11:30 a.m., Primary Clinicians (if any):					
		ncy room) for Evaluation."					
		ome to Hospital Transfer					
		esident #46's responsible					
	· •	he transfer via phone. ce that written notification					
		esident or responsible party					
		son for transfer on 6/8/18.					
	On 6/22/18 at 9:20 a.	m., an interview was licensed practical nurse) #1.					
	When asked if she wo						
		dent or representative					
	explaining the reason	for hospital transfer, LPN					
	#1 stated the nursing and not written.	provides verbal notification					
	On 6/22/18 at 9:35 a.	m., an interview was					
	conducted with OSM	(other staff member) 1, the #1 stated that she was not					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
495394	B. WING		C 06/22/2018		
		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00/22/2010		
Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	D BE COMPLETION		
transfers. o.m., ASM #1, the 2, the DON (Director of 4, the Regional Director of de aware of the above d, "Transferring Guest to the ress the above concerns. croutaneous endoscopic be used to deliver nutrition, nes directly into the patient's I require a tube if they are fely, putting them at risk of nk and medicines into their on was obtained from The Health. nih.gov/pubmed/26016095. vs a feeding tube to be put e. This information was ational Institutes of Health. ov/publications/dictionaries/c ostomy. facility staff failed to provide the responsible party for a al on 3/9/18 and 4/6/18. mitted to the facility on d on 4/13/18 with diagnoses e not limited to type two tion, heart failure, and high	F 62	3			
		A BUILDING 495394 B. WING ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) F 62 I transfers. D.m., ASM #1, the 2, the DON (Director of 4, the Regional Director of de aware of the above ad, "Transferring Guest to the lress the above concerns. Froutaneous endoscopic be used to deliver nutrition, nes directly into the patient's I require a tube if they are fely, putting them at risk of nk and medicines into their on was obtained from The Health. nih.gov/pubmed/26016095. A BUILDING PREFIX TAG F 62 ID PREFIX TAG F 62 In the provide the responsion of the provide the patient's I require a tube if they are fely, putting them at risk of nk and medicines into their on was obtained from The Health. nih.gov/pubmed/26016095. A BUILDING ID PREFIX TAG F 62 ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG ID PREFIX	A BUILDING 495394 A STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL S.C. IDENTIFYING INFORMATION) D PREFIX TAG F 623 It transfers. D.m., ASM #1, the 2, the DON (Director of 4, the Regional Director of de aware of the above and, "Transferring Guest to the fress the above concerns. Brecutaneous endoscopic be used to deliver nutrition, nes directly into the patient's I require a tube if they are fely, putting them at risk of nix and medicines into their on was obtained from The Health. nih.gov/pubmed/26016095. Ivis a feeding tube to be put e. This information was ational Institutes of Health ov/publications/dictionaries/c ostomy. facility staff failed to provide the responsible party for a al on 3/9/18 and 4/6/18. mitted to the facility on d on 4/13/18 with diagnoses e not limited to type two tion, heart failure, and high dent #50's most recent MDS		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495394	B. WING	B. WING		C 06/22/2018		
	ROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE ION AIR, VA 23235	1 0011	22/23/10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 623	date) of 5/7/18. Resicognitively intact in the decisions, scoring 12 Interview for Mental Sinterview of Resident # that she was transfer due to a fall. The follor "Found on floor next 4:05 p.m. No neuro on RR (respirations) is 2 134/92. Unable to ex (complained) pain in and order received to Daughter (Name of direquests (Name of host time to (Name of hospital)." Review of Resident # evidence that the RP notified in writing of the transfer to the hospital Further review of Resident # evidence that she had hospital for the secon following was documed pm 70 and taken in R drowsy. CNA (certifier room for VS (vital signorm).	ARD (assessment reference dent #50 was coded as a le ability to make daily out of 15 on the BIMS (Brief Status) Exam. 50's clinical record revealed red to the hospital on 3/9/18 owing was documented: to bed on R (right) side at hanges noted. Pulse is 124 4 BP (blood pressure) is stend R (right) leg in bed, c/o hip area. Physician notified a send guest out at 4:10 p.m. aughter), notified, and ospital). Transported at this pital) via (Name of EMT transport] Service). " 3/9/18 documented the attransfer sheet, copy of code sheet and face sheet R (emergency room) at 150's clinical record failed to (responsible party) was the reason for Resident #50's	F	523				

AND DUAN OF CODDECTION INTERCATION NUMBER.		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495394	B. WING			C 6/22/2018
	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF BON AIR			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 0	012212010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	washcloths used to response without su sugar at 32 with Glu called from nurses s RR (respiratory rate 134/82 manually. A from guests portable unsuccessful, no an medical technicians report given verbally glucose results writt Nursing) texted at the message left on onnumber for (Name of Review of Resident evidence that the RI notified in writing of transfer to the hospital conducted with LPN When asked if she wonotification to the resexplaining the reason #1 stated the nursing and not written. On 6/22/18 at 9:35 a conducted with OSN social worker. OSM involved with hospital on 6/22/18 at 12:02 administrator, ASM involved with hospital operations, were marked to the sugar and the	p.m. Cool H20 (water) and attempt to get verbal ccess. At 5:10 p.m., blood cagon (1) given and 911 tation per staff. Pulse is 102, 16, BP (blood pressure) ttempt made to call daughter phone in room at this time swer, EMTs (emergency arrived at 5:15 p.m. with with vital signs and blood en. DON (Director of its time with information and call physician's emergency rephysician) at this time." #50's clinical record failed to perform (responsible party) was the reason for Resident #50's tall on 4/6/18. a.m., an interview was (licensed practical nurse) #1. would provide written sident or representative in for hospital transfer, LPN ge provides verbal notification a.m., an interview was a (other staff member) 1, the interview was a form (other staff member) 1, the int	F 62	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495394	B. WING _			C 06/22/2018
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF BON AIR				STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	E	00/22/2010
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F 623	used to treat severe	on is an emergency medicine hypoglycemia (low blood	F 6	23		
	obtained from The N	atients. This information was lational Institutes of Health. n.nih.gov/pubmedhealth/PMH letails.				
	3. For Resident #39, the facility staff failed to evidence that the responsible party and ombudsman was provided with written notification of the hospital transfer of 4/19/18.					
	6/13/17 and readmit hospitalization, with limited to stroke, her disease, diabetes, a prostatic hyperplasia stenosis, high blood alcohol abuse, and a recent MDS (Minimusignificant change a (Assessment Referencesident was coded)	dmitted to the facility on ted on 4/26/18 after a brief the diagnoses of but not miplegia, Parkinson's nxiety disorder, benign a, dementia, dysphagia, spinal pressure, osteoarthritis, atrial fibrillation. The most um Data Set) was a ssessment with an ARD ence Date) of 5/4/18. The as severely cognitively make daily life decisions.				
	resident went to the of the nurse's notes dated for when the r On 6/21/18 at 4:35 p #1 (Registered Nurs resident is sent to the supposed to write a	cal record revealed that the hospital on 4/19/18. A review failed to reveal any notes esident went to the hospital. o.m., in an interview with RN e), she stated that when a e hospital, nursing is note why someone went to mplete the "Interact" form.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	· /	COMPLETED		
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	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	<u>'</u>	00/22/2010	
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F 623	(RP), RN #1 stated done by phone. When asked about processing to RP explaining reashook her head "no" so." When asked if notification of the tra #1 stated, "Nursing of the Computer of the Italy and	notifying the responsible party that it is on the form, and is providing written notification ison for transfer, RN #1 and stated, "No, I don't think nursing provides written insfer to the Ombudsman, RN does not notify Ombudsman." a.m., in an interview with OSM ober, the social worker), she is involved in any capacity ransferred to the hospital. cal record revealed the cospital Transfer Form" and I to evidence that the is provided with written was no evidence that the rovided with written in the provided	F 6	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495394	B. WING			06/22/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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I TE LAU	RELS OF BON AIR			E	BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	time, and a glitch in the private pay residents the facility pulls up in Ombudsman. When was notified of Reside stated no. No further information the survey. 4. For Resident #110 evidence that the residence that the process of but not chronic thrombosis, a pressure ulcer, dysphidisorder, benign prosichronic obstructive purecent MDS (Minimur admission/5-day asset (Assessment Referen MDS was incomplete prior to the completion A review of the clinical resident went to the horizontal treatment of the tresident did not return 3/21/18 at 4:00 a.m., first round at 1230 a.m., first round at 1230 a.m. elevated and had about this mouth. noted from out his mouth or	ne system was not including on the printed discharge list the system to send to the asked if the Ombudsman ent #39's discharge, ASM #1 In was provided by the end of the facility staff failed to ponsible party was provided on of the hospital transfer of the hospital transfer of the dimitted to the facility on ed on 3/21/18 with the limited to respiratory failure, alcohol abuse, cervicalgia, angia, schizoaffective tatic hyperplasia, and almonary disease. The most in Data Set) was an essment with an ARD and the most of 3/21/18. The due to the resident leaving in of the MDS. All record revealed that the dospital on 3/21/18. The n. A nurse's note dated documented, "Noted on the m., guest HOB (head of bed) normal breathing, breathing it yellow drainage coming in to a towel on his chest. In the discontinuous	F	623			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495394	B. WING		0.0	C 6/22/2018
	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF BON AIR			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		5/22/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 623	upper bases were full (temperature), 110 (168/88 (blood press (pulse oximetry read saturations]). MD/D doctor/director of nu notified w/N.O. (with (name of hospital) to (treat), noted and re at at {sic} 1240a.m Medical Technician) carried guest out via Further review of the reveal any evidence was notified in writin hospital on 3/21/18. On 6/21/18 at 4:35 p #1 (Registered Nurs resident is sent to th supposed to write a the hospital, and con When asked about to (RP), RN #1 stated done by phone. Whe written notification to transfer, RN #1 shoot "No, I don't think so. provides written notion ombudsman, RN #1 notify Ombudsman." On 6/22/18 at 9:51 at #1 (Other Staff Mem stated that she is not	d and blue. Lung sounds to all. VS (vital signs) 98.9 pulse), 24 (respirations), ure), unable to obtain a pox ling [reading of oxygen ON/RP (medical rsing/responsible party) anew order) send guest to eval (evaluate) and tx ceived. Called 911 dispatch Several EMT'S (Emergency arrived at 1245 a.m., and a stretcher." e clinical record failed to that the responsible party g of the transfer to the o.m., in an interview with RN e), she stated that when a e hospital, nursing is note why someone went to mplete the "Interact" form. notifying the responsible party that it is on the form, and is en asked about providing or RP explaining reason for ok her head "no" and stated, "When asked if nursing fication of the transfer to the I stated, "Nursing does not	F 62	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495394	B. WING	B. WING		C 06/22/2018		
	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 001	22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 623	"Interact" form failed responsible party was notification. There was Ombudsman was pronotification. On 6/22/18 at 12:30 p Staff Member, the Ad (the Director of Nursifindings. The facility evidence that any tra documentation was constituted in the company of th	al record revealed the spital Transfer Form" and to evidence that the sprovided with written as no evidence that the evided with written o.m., ASM #1 (Administrative ministrator) and ASM #2 ang) were made aware of the was not able to locate any	F	623				
	No further information was provided by the end of the survey. 5. The facility staff failed to provide written notification to the resident and responsible party (RP) and of a facility initiated transfer to the hospital on 06/12/18 for Resident # 64. Resident # 64 was admitted to the facility on 02/14/18 with a readmission of 03/13/18 with diagnoses that included but were not limited to malignant neoplasm (1) of the larynx (2), gastroesophageal reflux disease (3), chronic obstructive pulmonary disease (4), tracheostomy (5) and benign prostatic hyperplasia (6). Resident # 64's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/18/18, coded Resident # 64 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495394	B. WING _		06/22/2018	
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF BON AIR				STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		00/22/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 623	decisions. The nurse's "Progre dated 06/12/18 doct Following up from progre dated 06/12/18 doctors are sold to the receiving facilitations. The nurse's "Progre dated 06/13/18 doctors (Name of Hospital)." The nurse's "Progre dated 06/13/18 doctors." The nurse's "Progre dated 06/13/18 doctors." On 06/22/18 at 10:0 conducted with RN (asked describe what to the receiving facilit transferred, RN # 1 physician are notified is offered by nursing and a transfer form the resident." When	ss Notes" for Resident # 64 umented, "22:30 (10:22 p.m.) revious shift. Guest lab critical. N.O. (new order) from Name of Physician) to send lospital) for further evaluation. ty) notified. (Name of RP) guest. Guest sent out via c) accompanied by RP to	F 6	23		
	Review of Resident evidence documents	# 64's clinical record failed to ation of written notification of ransfer of Resident # 64 on				

AND DIAN OF CORRECTION INDESTRUCTION NUMBERS		` '	PLE CONSTRUCTION G	· /	(X3) DATE SURVEY COMPLETED		
		495394	B. WING _			C 06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		00/22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 623	(administrative staff ASM # 2, director of the above findings.) No further information References: (1) The term "malign of cancerous cells the too ther sites in the beinvade nearby (locall Malignant cells tend growth and DO NOT in their genetic maker resistant to treatmen detectable traces of destroyed. This into the website: https://medlineplus.g. (2) The larynx, or voice and performs several body. The larynx is in breathing, and voice produced when the avocal cords causes to sound waves in the produced was obtained from the https://medlineplus.g. htm. (3) Stomach content the esophagus and in was obtained from the was obtained from the was obtained from the sound	eximately 12:00 p.m., ASM member) # 1, administrator, nursing were made aware of an was provided prior to exit. ancy" refers to the presence at have the ability to spread body (metastasize) or to y) and destroy tissues. to have fast, uncontrolled die normally due to changes sup. Malignant cells that are than may return after all them have been removed or formation was obtained from ov/ency/article/002253.htm. The box, is located in the neck in important functions in the envolved in swallowing, production. Sound is air which passes through the hem to vibrate and create obarynx, nose and mouth. It determined by the amount and folds. This information he website: ov/ency/imagepages/19708.	F 6	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495394	B. WING _	B. WING		C 06/22/2018	
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION DATE	
F 625 SS=E	can lead to shortness was obtained from the https://www.nlm.nih.g (5) A surgical procedu through the neck into tube is most often pla provide an airway and the lungs. This tube is or trach tube This in from the website: https://medlineplus.gc (6) An enlarged prost obtained from the web https://www.nlm.nih.g statebph.html. Notice of Bed Hold Pc CFR(s): 483.15(d)(1)(1)(1)(1)(2)(1)(2)(1)(2)(1)(2)(2)(1)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)	es it difficult to breath that of breath). This information e website: lov/medlineplus/copd.html. ure to create an opening the trachea (windpipe). A loced through this opening to do to remove secretions from a called a tracheostomy tube information was obtained lov/ency/article/002955.htm. ate. This information was obsite: lov/medlineplus/enlargedpro lolicy Before/Upon Trnsfr (2) bed-hold policy and return- before transfer. Before a lers a resident to a hospital or therapeutic leave, the lorovide written information to int representative that e state bed-hold policy, if resident is permitted to sidence in the nursing layment policy in the state of this chapter, if any;		625		8/3/18	

PRINTED: 07/20/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	1, ,	(X3) DATE SURVEY COMPLETED	
		495394	B. WING			C 06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00	722/2010	
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F 625	of this section. §483.15(d)(2) Bed-hot the time of transfer of hospitalization or ther facility must provide to resident representative specifies the duration described in paragraph This REQUIREMENT by: Based on resident in facility document revively, it was determed to provide the written facility-initiated transfer the survey sample, Resident/Responsible transfer to hospital for the facility staff fair documentation of bed Resident/Responsible transfer to hospital for and 4/6/18. 3. The facility staff fair documentation of bed Resident/Responsible transfer to hospital for and 4/6/18. 3. The facility staff fair written bed hold notification for the resident #39 or the real transfer to the hospital for the resident's representation.	pecified in paragraph (e)(1) ald notice upon transfer. At a resident for apeutic leave, a nursing to the resident and the ave written notice which of the bed-hold policy on (d)(1) of this section. The is not met as evidenced terview, staff interview, ew, and clinical record ined that facility staff failed bed hold notification for a per for four of 32 residents in pesident #46, #50, #39, #64. The determinant witten I hold to the ave Representative upon ar Resident #46 on 6/8/18. The determinant witten I hold to the ave Representative upon ar Resident #50 on 3/9/18 The determinant was provided to aveident representative upon	F	Resident #46, #50, #39 and #64 returned to the facility to the bed/ they were in prior to transfer. All residents have the potential to affected. Licensed nursing staff to be educ DON/Designee to provide written notification to the resident and or responsible party. DON/Designe morning clinical meeting to condumonitoring of transfers out of the ensure written notification of the lensure weekly x4, monthly, PRN and as indicated. Findings to be communicated to committee monthly and as indicated. Findings to be communicated to committee monthly and as indicated.	cated by bed hold their ee during uct quality facility to bed hold eks, then		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER		-	9	STREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE 3ON AIR, VA 23235	1 06/.	22/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	6/9/14 and readmitted that included but were weakness, urine reter absence of other spe with a gastronomy (1) high blood pressure, #46's most recent ME assessment was a 60 with an ARD (assess 5/9/18. Resident #46 cognitively intact in the decisions scoring 12 BIMS (Brief Interview Review of Resident # that he had gone out A SBAR (Situation, B Recommendation) for documented in part, the Evaluation: Decrease consciousnessResp ProductiveAbdomin pain/tenderness/disterabdomenSummarize evaluation: Please evenear the JTUBE (jejumpain and copious foul Care Clinician Notifie practitioner) Date: 6/8 Recommendations of Send to ER (emerger	admitted to the facility on don 6/13/18 with diagnoses enot limited to muscle ntion, post stroke, acquired cified parts of digestive tract and jejunostomy tube (2), and diabetes. Resident (2) (2) (2) (3) (3) (4) (4) (4) (5) (4) (4) (5) (4) (5) (4) (6) (6) (6) (6) (7) (7) (7) (7) (7) (7) (7) (7) (7) (7	F	625			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF BON AIR		ı	9	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 001	22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	policy was provided to representative upon to 6/8/18. Further review of Reservealed that he was on 6/13/18 with a diaginfection). On 6/22/18 at 9:20 a. conducted with LPN (When asked the procout to the hospital, LF first assess the reside transfer, notify the resemble (medical doctor), and transfer form. When for offering written no policy, LPN #1 stated supposed to send the residents at the time of that nurses should be hold policy was offered. On 6/22/18 at 12:02 padministrator, ASM #Nursing), and ASM #Operations, were macconcerns. ASM (adm the DON (Director of provide evidence that was offered to Reside. On 6/22/18 at 1:26 p. conducted with OSM the Director of Admissasked about the process.	the that a written bed hold of the resident/resident ransfer to the hospital on sident #46's clinical record admitted back to the facility gnosis of a UTI (urinary tract m., an interview was (licensed practical nurse) #1. Less of sending a resident PN #1 stated that she would ent to determine the need for sponsible party and MD then she would fill out a asked who was responsible tification of the bed hold that the nurses are a bed hold policy with the for transfer. LPN #1 stated a documenting that the bed ed. D.m., ASM #1, the 2, the DON (Director of 4, the Regional Director of 4, the Regional Director of 4, the Regional Director of 4 de aware of the above inistrative staff member) #2, Nursing) was asked to the written bed hold policy ent #46.	F	625			

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495394	B. WING		C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETI
F 625	hospital, nursing will EMS (emergency mansfer. OSM #4 state admissions will call the responsible party register as the state of the sta	if a resident goes out to the send the bed hold policy with edical services) at the time of ated that the next day the family or speak with the garding the bed hold. OSM oes not document this because she does not have at click care). OSM #4 stated the form that the admission en they ask the family about asked how to determine if then bed hold notice to the of transfer with EMS for the SM #4 stated, "Personally, I wer." Deed hold notification given to not be provided prior to exit. The pritten information to the guest active of this bed hold policy epitalization or a therapeutic derivation or a therapeutic serious directly into the patient's ill require a tube if they are afely, putting them at risk of rink and medicines into their tion was obtained from The	F 62	25	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		495394	B. WING _			C 22/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00:	
THE LAUF	RELS OF BON AIR			9101 BON AIR CROSSINGS DRIVE		
				BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 625	Continued From page	e 64	F 6	25		
		ntional Institutes of Health. Dv/publications/dictionaries/c ostomy.				
	1/6/14 and readmitted that included but were diabetes, atrial fibrilla blood pressure. Resid (minimum data set) a assessment with an Adate) of 5/7/18. Resideng cognitively intacted decisions, scoring 12 Interview for Mental Swas coded as requiring one staff member for	mitted to the facility on don 4/13/18 with diagnoses e not limited to type two tion, heart failure, and high dent #50's most recent MDS essessment was an annual ARD (assessment reference dent #50 was coded as et in the ability to make daily out of 15 on the BIMS (Brief Status) Exam. Resident #50 ng extensive assistance with bed mobility, toileting, and dextensive assistance from rs for transfers.				
	that she had first been on 3/9/18 due to a fall documented: "Found (right) side at 4:05 p.r Pulse is 124 RR (responders) is 134/92. bed, c/o (complained) notified and order reced:10 p.m. Daughter (Notified, and requests)	on floor next to bed on R m. No neuro changes noted. Dirations) is 24 BP (blood Unable to extend R leg in Dipain in hip area. Physician Dieived to send guest out at Name of daughter),				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495394	B. WING				22/2018
	ROVIDER OR SUPPLIER			9101 B	T ADDRESS, CITY, STATE, ZIP CODE ON AIR CROSSINGS DRIVE AIR, VA 23235	1 00/	22/2010
(X4) ID PREFIX TAG			ID PREFI TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	following: "Interfacility current orders, copy sent with squad for E (Name of hospital)." There was no evident policy was provided to representative upon 3/9/18. Review of Resident # that she arrived back with a diagnosis of a surgical repair. Further review of Resident # that she arrived back with a diagnosis of a surgical repair. Further review of Resident # that she arrived back with a diagnosis of a surgical repair. Further review of Resident # that she arrived back with a diagnosis of a surgical repair. Further review of Resident # that she arrived back with a diagnosis of a surgical repair. Further review of Resident # that she arrived back with a diagnosis of a surgical repair. Further review of Resident # that she arrived back with a diagnosis of a surgical repair. Further review of Resident # that she arrived back with a diagnosis of a surgical repair. Further review of Resident # that she arrived back with a diagnosis of a surgical repair. Further review of Resident # that she arrived back with a diagnosis of a surgical repair.	3/9/18 documented the y transfer sheet, copy of of code sheet and face sheet in the central transfer to the hospital on the facility on 3/13/18 hip fracture and post sident #50's clinical record insferred to the hospital for 1/6/18. The following was Sugar at 4:45 pm 70 and and. Guest is drowsy. CNA istant) enters room for VS and guest is unresponsive asting blood sugar) of 22 at water) and washcloths used		525			
	Attempt made to call portable phone in room on answer, EMTs (er technicians) arrived a verbally with vital sig written. DON (Direct	ressure) 134/82 manually. daughter from guests om at this time unsuccessful, mergency medical at 5:15 p.m. with report given ns and blood glucose results or of Nursing) texted at this and message left on on-call					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495394	B. WING _			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	CODE	09/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BI	
F 625	physician) at this time. There was no evided policy was provided representative upon 4/6/18. Further review of Reservealed that Reside on 4/13/18. On 6/22/18 at 9:20 a conducted with LPN When asked the producted with LPN When asked the producted to the hospital, Lifirst assess the reside transfer, notify the resident doctor), and transfer form. When for offering written in policy, LPN #1 states supposed to send the residents at the time that nurses should be hold policy was offer On 6/22/18 at 12:02 administrator, ASM Nursing), and ASM in Operations, were maconcerns. ASM (addithe DON (Director of the control of	nce that the written bed hold to the resident/resident transfer to the hospital on esident #50's clinical record ent #50 returned to the facility a.m., an interview was (licensed practical nurse) #1. Incess of sending a resident a.PN #1 stated that she would dent to determine the need for responsible party and MD and then she would fill out a masked who was responsible otification of the bed hold at the nurses are the bed hold policy with the er of transfer. LPN #1 stated the documenting that the bed ared. p.m., ASM #1, the #2, the DON (Director of the properties of the above ministrative staff member) #2, if Nursing) was asked to at the written bed hold policy with the written bed hold policy was asked to at the written bed hold policy was asked to at the written bed hold policy was asked to at the written bed hold policy was asked to at the written bed hold policy was asked to at the written bed hold policy	F6	525		
	conducted with OSN	o.m., an interview was // (Other staff member) #4, ssions and Marketing. When				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495394	B. WING			C 06/22/2018
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	, , , , , , , , , , , , , , , , , , ,	00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 625	bed hold policy at the OSM #4 stated that hospital, nursing will EMS (emergency metransfer. OSM #4 stated that responsible party registrated that she do information in PCC to access to PCC (point there was a separate office completes whether bed hold. When nursing sent the writt hospital at the time of resident or family, Odo not know the ansection of the example	cess for offering the written e time of a hospital transfer, if a resident goes out to the send the bed hold policy with edical services) at the time of ated that the next day he family or speak with the garding the bed hold. OSM bes not document this because she does not have at click care). OSM #4 stated form that the admission en they ask the family about asked how to determine if ten bed hold notice to the of transfer with EMS for the SM #4 stated, "Personally, I wer." Deed hold notification given to not be provided prior to exit. On is an emergency medicine hypoglycemia (low blood atients. This information was lational Institutes of Health. In.nih.gov/pubmedhealth/PMH letails. Called to evidence that a fication was provided to resident representative upon	F 6.	25		

AND DI AN OF CORRECTION IN IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		495394	B. WING			C 06/22/2018	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		, 30.22.20.0	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 625	prostatic hyperplasia stenosis, high blood alcohol abuse, and a recent MDS (Minimusignificant change as (Assessment Refere resident was coded impaired in ability to A review of the clinic resident went to the of the nurse's notes when the resident w A review of the "Nurs Transfer Form" did resignating that the was no documented on 4/19/18. On 6/22/18 at 9:51 at 10:02 #1 (Other Staff Mem stated that she is no when a resident is troop of the asked if it is documented of the stated of the	nxiety disorder, benign a, dementia, dysphagia, spinal pressure, osteoarthritis, atrial fibrillation. The most am Data Set) was a ssessment with an ARD ance Date) of 5/4/18. The as severely cognitively make daily life decisions. The cord revealed that the chospital on 4/19/18. A review failed to reveal any date for ent to the hospital. The cord reveal any date for ent to the hospital and there evidence that one was sent The cord reveal any date for ent to the hospital. The cord reveal any date for ent to the hospital and there evidence that one was sent The cord reveal any date for ent to the hospital. The cord reveal any date for ent to the hospital and there evidence that one was sent The cord reveal any date for ent to the hospital. The cord reveal any date for ent to the hospital and there evidence that one was sent The cord reveal any date for ent to the hospital and there evidence that one was sent The cord reveal any date for ent to the hospital and there evidence that one was sent The cord reveal any date for ent to the hospital and there evidence that one was sent The cord reveal any date for ent to the hospital and there evidence that one was sent The cord reveal any date for ent to the hospital and there evidence that one was sent The cord reveal any date for ent to the hospital and there evidence that one was sent The cord reveal any date for ent to the hospital and there evidence that the hospital any date for ent to the hospital any	F 62	25			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495394	B. WING			C 06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	ı	06/22/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 625	Continued From pag	ge 69	F 63	25			
	Staff Member, the A (the Director of Nurs findings.	PM, ASM #1 (Administrative dministrator) and ASM #2 ing) were made aware of the					
	No further information the survey.	on was provided by the end of					
	or the resident's rep	niled to provide Resident # 64 resentative written notification y when the resident was spital on 06/12/18.					
	set), a quarterly asso (assessment referen Resident # 64 as so interview for mental	t recent MDS (minimum data essment with an ARD ace date) of 05/18/18, coded oring a 14 on the brief status (BIMS) of a score of 0 nitively intact for making daily					
	dated 06/12/18 docu Following up from pi (laboratory) results of MD (medical doctor, guest to (Name of H RP (responsible par wanted to transport	ss Notes" for Resident # 64 imented, "22:30 (10:22 p.m.) revious shift. Guest lab critical. N.O. (new order) from Name of Physician) to send ospital) for further evaluation. ty) notified. (Name of RP) guest. Guest sent out via) accompanied by RP to					
	dated 06/13/18 docu p.m.) Guest arrived Hospital) accompan Guest made comfort	ss Notes" for Resident # 64 Imented in part, "19:313 (7:13 via w/c from (Name of ied by RP (Name of RP). table in room by writer and ng assistant), RP at bedside					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	\ , ,	(X3) DATE SURVEY COMPLETED	
	495394 B. WING			C 06/22/2018		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		0/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 625	conducted with RN (rasked describe what to the receiving facilit transferred RN # 1 st are notified by phone by nursing at the time transfer form is compresident." On 06/22/18 at 1:25 conducted with OSM director of admission asked about the propolicy at the time a rehospital, OSM # 4 statransferred to the hosfamily, the bed hold president at the time opolicy is attached to twith the resident." On 06/22/18 at 2:45 conducted with ASM member) # 2, directo a bed hold policy was or Resident # 64's rethe transfer to the hostated, "No." On 06/22/18 at approach to the hostated, "No." On 06/22/18 at approach (administrative staff ransfer to the hostated, "No."	a.m., an interview was egistered nurse) # 1. When documentation is provided y when a resident is ated, "The RP and physician, a bed hold policy is offered of the transfer, and a leted and sent with the co.m., an interview was (other staff member) # 4, as and marketing. When ess of providing a bed hold esident is transferred to the ated, "When a resident is spital, nursing calls the policy is sent with the f the transfer. The bed hold the transfer form and is sent oc.m., an interview was	F 62	25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495394	B. WING		C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 625	of cancerous cells to other sites in the invade nearby (local Malignant cells tend growth and DO NO in their genetic make resistant to treatmed detectable traces of destroyed. This in the website: https://medlineplus. (2) The larynx, or voor and performs sever body. The larynx is breathing, and voice produced when the vocal cords causes sound waves in the The pitch of sound in of tension on the voor was obtained from the https://medlineplus.htm. (3) Stomach content the esophagus and was obtained from the things://www.nlm.nih (4) Disease that macan lead to shortnes was obtained from the things://www.nlm.nih (5) A surgical proce	nancy" refers to the presence hat have the ability to spread body (metastasize) or to ally) and destroy tissues. It to have fast, uncontrolled T die normally due to changes eup. Malignant cells that are not may return after all them have been removed or normation was obtained from gov/ency/article/002253.htm. Dice box, is located in the neck all important functions in the involved in swallowing, are production. Sound is air which passes through the them to vibrate and create pharynx, nose and mouth. It is determined by the amount and folds. This information the website: gov/ency/imagepages/19708. Atts to leak back, or reflux, into irritate it. This information the website:gov/medlineplus/gerd.html.	F 62	25	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		495394	B. WING _		06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 625 F 641 SS=D	tube is most often pla provide an airway and the lungs. This tube is or trach tube This ir from the website: https://medlineplus.go (6) An enlarged prost obtained from the wel https://www.nlm.nih.g statebph.html. Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy	ced through this opening to d to remove secretions from scalled a tracheostomy tube of the company of the control of the contr	Fé		8/3/18	
	§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record, it was determined that the facility staff failed to maintain an accurate MDS (minimum data set) assessment for one of 32 residents in the survey sample, Resident #81. The facility staff failed to accurately code Resident #81's MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 05/23/18, for safety devices. The findings include: Resident #81 was admitted to the facility on 06/24/09 with a readmission of 03/30/11 with diagnoses that included but were not limited to Alzheimer's disease (1) hypertension (2), diabetes mellitus (3), depressive disorder (4),			Resident #81s MDS has been coded correctly. A quality review of the MDS of guests w safety devices has been performed. The MDS coordinator/designee to educate MDS Nurses on accurate MDS documentation. The MDS coordinator/designee during morning clinical meeting to conduct quality monitoring of MDS accuracy 5x week x week, weekly x4 weeks and then month PRN and as indicated. Findings to be communicated to the QA committee monthly and as indicated. Quality monitoring schedules modified based on findings.	d nly,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495394	B. WING			C 06/22/2018	
	ROVIDER OR SUPPLIER			٤	STREET ADDRESS, CITY, STATE, ZIP CODE 0101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 001	22/2010
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 641	set), a quarterly asse (assessment reference Resident # 81 as soo interview for mental s - 15, 3 (three) - being cognition intact for material Resident # 81 was coassistance of one state daily living. Review of revealed it was coded and F. Other alarm." The physician's order 04/01/2018 documents belt while in whe 01/10/2018." "Sensor Date: 01/10/2018." The eTAR (electronic record) for Resident # documented, "Alarming self-releasi chair. Start Date: 01/10/2018." On 06/22/18 at 11:10 conducted with RN (regarding section "P0 81's quarterly MDS at 05/23/18. After review RN # 5 stated, "(Resicoded for the bed ala was an oversight." W	recent MDS (minimum data assment with an ARD ce date) of 05/23/18, coded ring a 3 (three) on the brief tatus (BIMS) of a score of 0 severely impaired of aking daily decisions. Oded as requiring extensive of member for activities of of section "P0200 Alarms" das zeros for "A. bed alarm as zeros for "A. bed alarm as for Resident # 81 dated ted, "Alarming self-releasing tel chair. Start Date: a pad alarm to bed. Start treatment administration # 81 dated June 2018 In great belt while in wheel 10/2018." bed. Start Date: a.m., an interview was registered nurse) # 5 sessment with an ARD of wing the MDS assessment, dent # 81) should have been remand the alarming belt. It when asked what guidance ing the MDS, RN # 5 stated,	F	641			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495394	B. WING			C 06/22/2018	
	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 2101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00.	
(X4) ID PREFIX TAG			I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
F 641	Manual Version 1.15 Alarms. Item Rational Life o An alarm is any phy that monitors resident staff, by either audible movement is detected chair and floor sensor resident's clothing, mor elopement/wander o While often used as resident's fall prevent alarms to prevent falls therefore, alarm use in sole intervention in the o The use of an alarm plan of care does not adequate supervision individualized, persor o Adverse consequen but are not limited to, related to the alarm is sleep disturbances; a of movement, dignity, Steps for Assessmen 1. Review the resider physician orders, nurs documentation) to de during the 7-day look-	sment Instrument 3.0 User's October 2017" documented, ale. Health-related Quality of sical or electronic device the movement and alerts the end or inaudible means, when ad, and may include bed, and intervention in a sion strategy, the efficacy of a has not been proven; must not be the primary or e plan. In as part of the resident's eliminate the need for an an apart of the resident's eliminate the need for anxiety, or agitation ound; decreased mobility; and infringement on freedom and privacy. It is medical record (e.g., ases' notes, nursing assistant termine if alarms were used back period. It is staff to determine the and physical	F	641			
	alarm/device is in place resident avoid standing	ce. For example, does the ng up or repositioning					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495394	B. WING			C 06/22/2018	
	ROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE SON AIR, VA 23235	1 001	22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	alarm? On 06/22/18 at appro (administrative staff in ASM # 2, director of in the above findings. No further information. References: (1) A brain disorder the person's ability to carrinformation was obtain https://www.nlm.nih.gsease.html. (2) High blood pressure obtained from the wenttps://www.nlm.nih.gessure.html. (3) A chronic disease regulate the amount of information was obtain https://www.nlm.nih.go01214.htm. (4) Depression may be blue, unhappy, miser. Most of us feel this went of the short periods. Clinical disorder in which feel or frustration interfered or more. This information website: https://medlineplus.go/	o fear of setting off the eximately 12:00 p.m., ASM member) # 1, administrator, nursing were made aware of n was provided prior to exit. nat seriously affects a ry out daily activities). This ined from the website: gov/medlineplus/alzheimersdi ure. This information was	F	641			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE COMP	SURVEY
		495394	B. WING			l	C 22/2018
	ROVIDER OR SUPPLIER			910	REET ADDRESS, CITY, STATE, ZIP CODE 01 BON AIR CROSSINGS DRIVE DN AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	#summary. (6) Low iron. This info	e 76 pov/medlineplus/anxiety.html prmation was obtained from pov/medlineplus/anemia.html	F	641			
F 656 SS=E	F 656 Develop/Implement Comprehensive Care Plan		F	656			8/3/18

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	EICATION NI IMBED:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD			، ا	C
		495394	B. WING				22/2018
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
				و	101 BON AIR CROSSINGS DRIVE		
THE LAUF	RELS OF BON AIR			E	BON AIR, VA 23235		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 656	Continued From pag	e 77	F	656			
	resident's representa						
		als for admission and					
	desired outcomes.						
		eference and potential for					
	' '	cilities must document					
		's desire to return to the					
	community was asse	essed and any referrals to					
		es and/or other appropriate					
	entities, for this purpo						
	(C) Discharge plans						
	plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this						
		h in paragraph (c) of this					
	section.	T : 4 4					
	by:	Γ is not met as evidenced					
	·	view, resident interview,			Resident #102 care plan for fluid		
	facility document rev	iew and clinical record			restriction has been updated. Resident		
	l '	nined that the facility staff			#37 comprehensive care plan has bee		
	1	ment the care plan for nine of			updated to include non-pharmacologic	al	
		urvey sample, Resident #s			interventions. Resident #64		
	102, 37, 64, 6, 50, 74	1, 311, 108 and 23.			comprehensive care plan for oxygen h		
	4 Th - f :::: + - # f -	:!			been updated. Resident's #6 weights		
		ailed to follow/implement the plan for Resident # 102's			being obtained as per Physician orders Resident #50 fall mat is in place as per		
	fluid restriction.	plan for Resident # 1025			care plan. Resident#74 no longer resid		
	ilula restriction.				in the facility. Resident #108 medicatio		
	2. The facility staff fa	ailed to follow Resident # 37's			are being administered as per Physicia		
	_	plan for implementing non-			order. Resident #23 care plan is being		
	pharmacological inte				followed for fluid restrictions. Resident		
		·			#311 weights are being observed as pe	er	
		ailed to follow/implement plan for the administration of			Physician order.		
	oxygen.	-			All residents have the potential to be	ſ	
					affected.	ſ	
	4a. The facility staff f	ailed to obtain daily weights			DON/Designee to educate MDS Nurse	:S	
		the physician's orders and			on updating comprehensive care plans	,	
	the comprehensive c	are plan.			DON/designee to re-educate Nursing s	staff	
					on obtaining weights as per Physician	ſ	
	4b. The facility staff f	ailed to obtain weights for			orders, DON/designee to educate Nurs	sina	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495394	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	453354	B. WING		TREET ARRESC CITY STATE ZIR CORE	06/	22/2018
NAIVIE OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF BON AIR				101 BON AIR CROSSINGS DRIVE ON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	e 78	F	356			
	Resident #6, prior to orders and the compr	dialysis per the physician's rehensive care plan.			staff on ensuring care plans are being followed for fall interventions,		
	1	The facility staff failed to ensure a fall mat was place per the comprehensive plan of care for			DON/designee to educate Nursing staf regarding following Physician orders fo medication administration and fluid restrictions. Don/designee during Morn Clinical Meeting to conduct quality	r	
	6. The facility staff fai comprehensive care pordered daily weights	plan for obtaining physician		monitoring 5x week x1 week, weekly and then monthly, PRN and indicated Findings to be communicated to the committee monthly and as indicated. Quality monitoring schedules modified based on findings.			
	7. The facility staff fai comprehensive care placed for Resident #311.	led to follow the plan to obtain daily weights					
	8. The facility staff fai comprehensive care pedications as ordere #108.						
		led to follow Resident #23's plan for fluid restrictions.					
	The findings include:						
	-	iled to follow/implement the plan for Resident # 102's					
	02/10/15 with a readr diagnoses that includ respiratory failure (1)	lux disease (3), depressive					
	data set), a quarterly	st recent MDS (minimum assessment with an ARD ce date) of 06/01/18, coded					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495394	B. WING			C 06/22/2018	
	ROVIDER OR SUPPLIER			٤	STREET ADDRESS, CITY, STATE, ZIP CODE 0101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 001	22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	interview for mental single processions. Resident independent and registaff member for activation of the physician's order 11/30/2017 to 06/30/(cubic centimeters)/consumption of the physician's order 11/30/2017 to 06/30/(cubic centimeters)/consumption of the physician's order 11/30/2017 to 06/30/(cubic centimeters)/consumption of the physician	coring a 14 on the brief status (BIMS) of a score of 0 itively intact for making daily # 102 was coded as being uiring the assistance of one vities of daily living. rs for Resident # 102 dated 2018 documented, "1800cc lay. Fluid restriction. 20 ml (milliliters) on Day shift, ing) shift, 120 ml on Night 25/2018." c medication administration # 102 dated June 2018 failed unt of fluid Resident # 102 day shift on 06/18/18. care plan for Resident # 102 day shift on 06/18/18. care plan for Resident # 102 documented, "Need. FLUID: attoin related to: Diuretic use, bx (diagnoses) of Cirrhosis, DM (diabetes mellitus), and the company of irritable bowel. Date attended to the company of the compa	F	656			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495394	B. WING			C 06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		1 00/	22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	can't tell how they had nurse's progress noted 06/01/18 through 06/1 fluid intake for the dark documented. When a to document a reside stated, "If they have to them into congestive their electrolytes." On 06/22/18 at 10:55 conducted with LPN adescribe the purpose stated, "It's an outline needs." When asked plan LPN # 9 stated, should be followed." # 102's missing fluid stated the care plan when the care plan	urse's notes, but if it isn't, d." LPN # 2 reviewed the es for Resident # 102 dated 18/18. LPN # 2 stated the y shift on 06/18/18 was not easked why it was important nt's fluid intake LPN # 2 oo much fluid it could put heart failure or throw off a.m., an interview was # 9. When asked to of a care plan LPN # 9 e of what care the resident I about following the care "If it's on the care plan it When asked about Resident intake on 06/18/18, LPN # 9 evas not followed. eximately 12:00 p.m., ASM member) # 1, administrator, nursing were made aware of a was provided prior to exit. se. It leads to inflammation bunding tissues. It can also This information was	F	656			

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		' '	LE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED		
		495394	B. WING			C 06/22/2018	
	ROVIDER OR SUPPLIER	10001		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1	06/22/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 656	001214.htm. (3) Stomach contents the esophagus and it was obtained from the https://www.nlm.nih.g. (4) Depression may blue, unhappy, miser Most of us feel this was ont periods. Clinical disorder in which fee or frustration interfer or more. This inform website: https://medlineplus.g. (5) Fear. This inform website: https://www.nlm.nih.g. #summary. (6) Low iron. This inform website: https://www.nlm.nih.g. #summary. 2. The facility staff facomprehensive care pharmacological interpharmacological interpharmacological interpheral vascular of (2), chronic kidney didisorder (4), anxiety	s to leak back, or reflux, into ritate it. This information e website: gov/medlineplus/gerd.html. De described as feeling sad, able, or down in the dumps. ay at one time or another for all depression is a mood lings of sadness, loss, anger, e with everyday life for weeks ation was obtained from the cov/ency/article/003213.htm. Dation was obtained from the gov/medlineplus/anxiety.html Dormation was obtained from gov/medlineplus/anemia.html Dilled to follow Resident # 37's plan for implementing non-rventions for pain. Dimitted to the facility on mission of 04/03/18 with led but were not limited to isease (1) diabetes mellitus sease (3), depressive	F 65	6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495394	B. WING			C 06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	<u> </u>	00/22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 656	(assessment refered Resident # 37 as so interview for mentary - 15, 10 - being mointact for making data The physician's ordout/2018 documer.5-325 MG (millight (Hydrocodone-Ace tablet by mouth every pain max (maximum (tablets)." The EMAR (electrodecord) for Resider documented the abstract Further review of the Tablet. 7.5-325 MG On 04/06/18 at 9:2 (four). On 04/07/18 at 153 of 9 (nine) and at 2	sessment with an ARD ence date) of 04/24/18, coded coring a 10 on the brief all status (BIMS) of a score of 0 derately impaired of cognition aily decisions. ders for Resident # 37 dated ented, "Norco (7) Tablet.	F 65				
	(nine), at 1615 (4:1 (eight) and at 2232 of 8 (eight). On 04/09/18 at 205 of 3 (three). On 04/13/18 at 130 of 6 (six). On 04/14/18 at 11: (six) and at 2017 (8 (three). On 04/ 15/18 at 5:1 (eight).	0 a.m. with a pain level of 9 6 p.m.) with a pain level of 8 (10:32 p.m.) with a pain level 67 (8:57 p.m.) with a pain level 96 (1:06 p.m.) with a pain level 96 a.m. with a pain level of 6 8:17 p.m.) with a pain level of 3 912 a.m., with a pain level of 8 98 a.m., with a pain level of 7					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495394	B. WING		C 06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	00/22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLETION	
F 656	of 3 (three). On 04/21/18 at 8:55 (four) and at 1714 (state). On 04/22/18 at 8:12 (three) and at 1815 of 8 (eight). On 04/28/18 at 1:06 (four). On 04/28/18 at 1:06 (four). On 04/30/18 at 1709 of 6 (six). The EMAR (electror record) for Resident documented the aboreview of the EMAR 7.5-325 MG was ad On 05/05/18 at 1809 of 4 (four). On 05/06/18 at 1739 of 5 (five). On 05/15/18 at 10:2 (five). On 05/15/18 at 9:08 (six). On 05/19/18 at 1739 of 5 (five). On 05/20/18 at 8:23 (three) and at 1815 of 6 (six). The EMAR (electror record) for Resident documented the abore compared to the abore comp	3 (8:33 p.m.) with a pain level a.m., with a pain level of 4 5:14 p.m.) with a pain level of a.m., with a pain level of 3 (6:15 p.m.) with a pain level a.m., with a pain level of 4 9 (5:09 p.m.) with a pain level nic medication administration # 37 dated May 2018 ove physician's order. Further revealed the Norco Tablet. ministered as follows: 6 (6:06 p.m.) with a pain level 10 (5:39 p.m.) with a pain level 11 (5:39 p.m.) with a pain level 12 a.m. with a pain level of 6 13 a.m.) with a pain level of 6 15 (5:53 p.m. with a pain level a.m. with a pain level of 3 (6:18 p.m.) with a pain level nic medication administration # 37 dated June 2018 ove physician's order. Further revealed the Norco Tablet.	F 65	6		

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495394	B. WING		C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 656	7.5-325 MG was ac 9:25 a.m., with a particle of the comprehensive dated 04/04/2018 of for pain r/t (related amputation) and rig amputation), H/O (I vascular accident) hemiparesis, CKD Diabetes, neuropat (coronary artery dis (peripheral vascular Retinopathy. Date "Interventions" it do for comfort with phy Date initiated: 04/06/18 through 0 documentation of neuroscience of the composition of	dministered on 06/18/18 at ain level of 4 (four). e care plan for Resident # 37 documented, "Need. Potential to): AKA (above the knee that BKA (below the knee history of) CVA (cerebral [stroke], with right (chronic kidney disease), hy, HTN, hyperlipidemia, CAD sease), anemia, PVD r disease) Vertigo, initiated: 04/04/2018." Under ocumented, "Assist to position ysical support as necessary.	F 65	6	
	conducted with LPI 9. When asked to plan, LPN # 9 state the resident needs. the care plan, LPN plan it should be fo Resident # 37's cor documenting "Assis physical support as the care plan was r On 06/22/18 at app (administrative staf	55 a.m., an interview was N (licensed practical nurse) # describe the purpose of a care d, "It's an outline of what care " When asked about following # 9 stated, "If it's on the care llowed." When asked about mprehensive care plan st to position for comfort with a necessary", LPN # 9 stated not followed. proximately 12:00 p.m., ASM f member) # 1, administrator, of nursing were made aware of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	' '	OMPLETED	
		495394	B. WING _			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	'	30,22,23
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	Continued From pag	ge 85	F 6	56		
	the above findings.					
	No further information	on was provided prior to exit.				
	blood vessels. It incl capillaries that carry Arteries can become called atheroscleros vessels and block bl Weakened blood ve- bleeding inside the blootained from the we	tem is the body's network of udes the arteries, veins and blood to and from the heart. It thick and stiff, a problem is. Blood clots can clog ood flow to the heart or brain. It is seels can burst, causing body.) This information was ebsite: gov/medlineplus/vasculardise				
	regulate the amount information was obtain	e in which the body cannot of sugar in the blood. This ained from the website: gov/medlineplus/ency/article/				
	they should. This inf the website:	aged and can't filter blood as ormation was obtained from gov/chronickidneydisease.htm				
	blue, unhappy, mise Most of us feel this v short periods. Clinic disorder in which fee or frustration interfer or more. This inform website:	be described as feeling sad, rable, or down in the dumps. way at one time or another for cal depression is a mood elings of sadness, loss, anger, re with everyday life for weeks nation was obtained from the gov/ency/article/003213.htm.				

AND DIAN OF CORRECTION IDENTIFICATION NUMBER			LE CONSTRUCTION	COMPLETED	
		495394	B. WING		C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 33/22/23 13
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 656	website: https://www.nlm.nil #summary. (6) Low iron. This i the website: https://www.nlm.nil (7) Hydrocodone is opioid is sometime Acetaminophen is increases the effect The combination or hydrocodone is use severe pain. This is the website: https://www.rxlist.cr mages-side-effects 3. The facility staff care plan for the ace Resident # 64 was 02/14/18 with a readiagnoses that incl malignant neoplasi gastroesophageal obstructive pulmon (5) and benign pro-	mation was obtained from the n.gov/medlineplus/anxiety.html nformation was obtained from n.gov/medlineplus/anemia.html n.gov/m	F 65		
	set), a quarterly as (assessment reference Resident # 64 as s interview for mental - 15, 14 - being cog	est recent MDS (minimum data sessment with an ARD ence date) of 05/18/18, coded coring a 14 on the brief al status (BIMS) of a score of 0 gnitively intact for making daily of # 64 was coded as requiring			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	· '	ATE SURVEY DMPLETED
		495394	B. WING			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 656	activities of daily livii Treatment, Procedu # 64 was coded for Tracheostomy care. An observation on 0 p.m., revealed Residenceiving oxygen from a tracheostomy tube mete on the O2 (oxy three and a half liter. An observation on 0 revealed Resident # watching television, oxygen concentrator. Observation of the ficoncentrator revealed minute. An observation on 0 revealed a nurse en per his request and observation on at 12 # 64, sitting up in be receiving oxygen from a tracheostomy tube mete on the O2 (oxy three and a half liter. An observation on 0 revealed Resident # watching television, oxygen concentrator. Observation of the fi	e of one staff member for ng. Under section "O. Special res and Programs" Resident "C. Oxygen therapy and E." 6/19/18 at approximately 6:00 dent # 64 was in bed an an oxygen concentrator via a. Observation of the flow regen) concentrator revealed per minute. 6/20/18 at 12:45 p.m., 64, sitting up in bed, receiving oxygen from an an an ar via a tracheostomy tube. How mete on the O2 (oxygen) and three and a half liter per closed the door. An action of the flow red, watching television, and an oxygen concentrator via a. Observation of the flow regen) concentrator revealed	F 65	56		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495394	B. WING		C 06/22/2018
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF BON AIR		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		06/22/2018	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 656	03/03/2018 through "Oxygen 5 (five) I/n (tracheostomy) eve 03/13/2018. Start I The EMAR (electrorecord) dated June documented, Oxygminute) via trach (tracheostomy on 06/21/18. The comprehensive dated 03/14/18 documented Resid tracheostomy on 06/21/18. The comprehensive dated 03/14/18 documented greathing (shortness of breat abnormal pulse, ox (HTN [hypertension pulmonary disease squamous cell cando3/14/2018." Under documented, "Admit reatment per physeffectiveness, side of medications and abnormal findings to Oximetry, Suction, elevate HOB (head On 06/22/18 at 10:conducted with LPI describe the purpos stated, "It's an outlineeds." When ask plan LPN # 9 stated	lers for Resident # 64 dated in 06/30/18 documented, in (liters per minute) via trach ery shift. Order Date: Date: 03/13/2018." Inic medication administration 2018 for Resident # 64 en 5 (five) I/min (liters per racheostomy) every shift. Start Further review of the EMAR ent # 64 received oxygen by 6/19/18, 06/20/18 and on The care plan for Resident # 64 cumented, "Need. Potential R/T (related to): SOB h), abnormal respiration, imetry,R/T cardiac condition, in COPD [chronic obstructive], Tracheostomy, Cancer, cer of lung). Date initiated: er "Interventions" it inister medication & (and) ician's order. Monitor for effects and adverse reactions treatments and report o physician. Oxygen, Pulse trach (tracheostomy) care,	F 65	6	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		ATE SURVEY DMPLETED
		495394	B. WING			C 06/22/2018
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	rate and the care pl medication & (and) order. Monitor for a adverse reactions of	g observed at the wrong flow an documenting "Administer treatment per physician's effectiveness, side effects and of medications and treatments	F 65	6		
	Oxygen, Pulse Oxir (tracheostomy) care LPN # 9 stated the	al findings to physician. metry, Suction, trach e, elevate HOB (head of bed)", care plan was not followed. roximately 12:00 p.m., ASM				
	(administrative staff ASM # 2, director o the above findings.	member) # 1, administrator, f nursing were made aware of on was provided prior to exit.				
	References: (1) The term "malig of cancerous cells to other sites in the invade nearby (local Malignant cells tender growth and DO NO in their genetic make resistant to treatmed detectable traces of destroyed. This is the website:	nancy" refers to the presence hat have the ability to spread body (metastasize) or to ally) and destroy tissues. It to have fast, uncontrolled T die normally due to changes leup. Malignant cells that are not may return after all form the have been removed or information was obtained from gov/ency/article/002253.htm.				
	and performs sever body. The larynx is breathing, and voic produced when the vocal cords causes sound waves in the	pice box, is located in the neck al important functions in the involved in swallowing, e production. Sound is air which passes through the them to vibrate and create pharynx, nose and mouth. is determined by the amount				

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495394	B. WING		06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 656	was obtained from https://medlineplus.htm. (3) Stomach conter the esophagus and was obtained from https://www.nlm.nih (4) Disease that macan lead to shortne was obtained from https://www.nlm.nih (5) A surgical procethrough the neck in tube is most often provide an airway at the lungs. This tube or trach tube This from the website: https://medlineplus. (6) An enlarged procetained from the whitps://www.nlm.nih statebph.html. 4a. The facility staff for Resident #6, pethe comprehensive Resident #6 was ac 12/6/17 with diagnolimited to end stage.	ocal folds. This information the website: gov/ency/imagepages/19708. Its to leak back, or reflux, into irritate it. This information the website: gov/medlineplus/gerd.html. Its so foreath). This information the website: gov/medlineplus/copd.html. Its dure to create an opening to the trachea (windpipe). A placed through this opening to and to remove secretions from the is called a tracheostomy tube information was obtained gov/ency/article/002955.htm. Its state. This information was website: gov/medlineplus/enlargedpro It failed to obtain daily weights in the physician's orders and	F 650			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	PLE CONSTRUCTION G	(X3	(X3) DATE SURVEY COMPLETED		
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	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF BON AIR			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	ı	06/22/2018	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	quarterly assessmentereference date) of 3 coded as being cogmake daily decision 15 on the BIMS (Briexam. Review of Resident summary) dated 6/1 following order: "Darecord- report gain of 24 hours or < (less tweek one time a daywas initiated on 4/13. Review of June 201 Administration Record- report gain of 24 hours or < (less tweek one time a daywas initiated on 4/13. Review of June 201 Administration Record following day 6/6/18, 6/7/18, 6/9/18, 6/9/18, 6/10/16/17/18, 6/18/18, 6/9/18, 6/10/16/17/18. The daily weight record following day 6/6/18, 6/9/18, 6/10/18. Further review of the weight was not obta 6/15/18. The follow from home." Review revealed Resident # dates. A weight shound the physician's dialysis.	mit with an ARD (assessment /5/18. Resident #6's was nitively intact in the ability to secoring 15 out of possible ef Interview for Mental Status) #6's POS (physician order /18, documented the ily Weights- obtain and of > (greater) than 3 pounds in than) 5 lbs (pounds) in one y for heart failure." This order 3/18. 8 MAR (medication order /3/18. 8 MAR (medication order /3/18.	F 6	56			
	blank space for 6/13	R also revealed a hole or 8/18. There was no note ight was not obtained.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00/22/2010
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F 656	Continued From page	ge 92	F 65	56	
	following for 6/20/18 note could not be for was not obtained for was not obtained for Review of Resident 3/19/18 did not addresident #6's renal documented the following daily weights as well on 6/21/18 at 12:00 conducted with Resident the facility staff percent of the time. On 6/21/18 at 12:31 conducted with LPN Resident #6's nurse weights were condustated if weights could click care), they may on the unit. This write book with LPN #2 for Resident #6 were appeared that daily completed. When a physician order and plan, LPN #2 stated determine why some the vital signs section book. LPN #2 then been done but not on the was the nurse worn 6/20/18. LPN #2 documented "Hold/stages" and the vital signs section was the nurse worn 6/20/18. LPN #2 documented "Hold/stages" and the vital signs section was the nurse worn 6/20/18. LPN #2 documented "Hold/stages" and the vital signs section was the nurse worn 6/20/18. LPN #2 documented "Hold/stages" and the vital signs section was the nurse worn 6/20/18. LPN #2 documented "Hold/stages" and the vital signs section was the nurse worn 6/20/18. LPN #2 documented "Hold/stages" and the vital signs section was the nurse worn 6/20/18. LPN #2 documented "Hold/stages" and the vital signs section was the nurse worn 6/20/18. LPN #2 documented "Hold/stages" and the vital signs section was the nurse worn 6/20/18. LPN #2	8 MAR documented the it: "Hold/See nurses note." A und indicating why this weight in this date. #6's cardiac care plan dated less obtaining daily weights. Care plan dated 3/19/18 owing intervention: "Obtain I as prior to dialysis sessions." p.m., an interview was ident #6. Resident #6 stated checked his weight about 50 p.m., an interview was (licensed practical nurse) #2, that shift. LPN #2 stated daily could not be found in PCC (point of the daily weight with the daily weight with above dates. Weights in the above dates. Weights in the above dates. Weights weights were not being sked if this was following the the comprehensive care, it was not. LPN #2 could not be weights were missing from an in PCC and in the weight stated the weights may have harted. LPN #2 confirmed who worked with Resident #6 could not recall why she see nurses note" on the June PN #2 stated she has only			

C 06/22/2018
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TION (X5) JLD BE COMPLETION OPRIATE DATE

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		, ,	DATE SURVEY COMPLETED		
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F 656	Resident #6 on 6/9/was not recorded in stated, "My CNAs go go." LPN #1 then he on 6/22/18 at 12:02 administrator, ASM in Nursing), and ASM in Operations, were material concerns. No further prior to exit. The facility policy title Plan" does not address and	en asked why she weight was completed for 18 and 6/10/18 if a weight the clinical record, LPN #1 et weights for me. I have to ung up the phone. p.m., ASM #1, the #2, the DON (Director of #4, the Regional Director of ade aware of the above information was presented ed, "Interdisciplinary Care ess following the care plan. and Perry's, Fundamentals of page 269 states "A written ates nursing care priorities to of page 269 states to pressionals. The nursing care ontinuity of care by listing eventions needed to achieve the complete care plan is the action. It provides direction of the plan plus the framework client's response to nursing	F 6	56		
	Resident #6, prior to orders and the comp Review of Resident summary) dated 6/1 following orders: "W	failed to obtain weights for dialysis per the physician's orehensive care plan. #6's POS (physician order /18, documented the eight prior to dialysis on				
		y, Friday." This order was "Daily Weights- obtain and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY LETED
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F 656	24 hours or < (less to week one time a day was initiated on 4/13 Review of Resident 3/19/18 documented "Obtain daily weight to dialysis sessions. Review of Resident (medication administ Resident #6 has had days: 6/1/18 6/4/18 6/6/18 6/6/18 6/15/18 6/15/18 6/15/18 6/15/18 6/15/18 6/18/18 6/15/18 6/18/18 6/15/18 6/18/18 6/15/18 6/18/18 6/15/18 6/18/18 6/15/18 6/18/18 6/20/18 On 6/4/18, 6/6/18, a was documented on these weights were weight for 6/4/18 co record. A weight for the paper weight log The dialysis communot be found in the control of the dialysis communot be found in the dialysis of the dialysis communot be found in the dialysis of the dialysis communot be found in the dialysis of the dialysis communot be found in the dialysis of	of > (greater) than 3 pounds in than) 5 lbs (pounds) in one of for heart failure." This order 3/18. #6's Renal Care Plan dated the following intervention: so as ordered as well as prior that the following intervention: #6's June 2018 MAR tration record) revealed that the dialysis on the following that dialysis on the following that obtained prior to dialysis. A culd not be found in the clinical following station. In the form for 6/4/18 could the found on the found on the found form for 6/4/18 could the found on the found form for 6/4/18 could	F	656			

i '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 656	6/6/18 was not prior recorded from 6/5/1 was documented: "\11:20 a.m." Review of the dialys 6/18/18 revealed the 6/18/18 was not prior recorded was from 6 following was documed 6/7/18 at 139 p.m." Further review of the resident was documented to the follow 6/11/18, and 6/15/18 was coded as being because he was at dialysis communicated 6/11/18 and 6/15/18 that the weights well dialysis. Further review of the blank or hole for the weight could not be weight could not be at the nursing station communication form blank for weight, incomot obtained prior to Review of the June following documented.	to dialysis. The weight was 8 at 11:20 a.m. The following Weight: 126.2, date: 6/5/18 at sis communication form dated at the weight documented for or to dialysis. The weight 6/7/18 at 1:39 p.m. The mented: "Weight 128.6, date "Weight 128.6, date "Bune MAR revealed that the mented as being "Absent from ing dialysis days: "6/8/18, 8." 6/11/18, and 6/15/18 could clinical record. Further review 1 revealed that Resident #6 1 "Absent from home" dialysis. Review of the tion form dated 6/8/18, 8, revealed blanks indicating re not obtained prior to be June 2018 MAR revealed a e dialysis day 6/13/18. A found in the clinical record. A found on the weight log kept in Review of dialysis in dated 6/13/18 revealed a dicating that the weight was	F 65	56				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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F 656	F 656 Continued From page 97		F 6	56			
	to evidence why his to dialysis.	weight was not obtained prior					
	conducted with Resi that the facility staff of percent of the time. On 6/21/18 at 12:31 conducted with LPN Resident #6's nurse the following order in dialysis on Monday,	p.m., an interview was dent #6. Resident #6 stated checked his weight about 50 p.m., an interview was (licensed practical nurse) #2, that shift. When asked what neant: "Weight prior to Wednesday, Friday," LPN #2 should be obtained prior to					
	dialysis. When aske the resident leave fo it meant for that day dialysis. LPN #2 stat the dialysis forms in obtained by the day Resident #6 leaves of	and if that meant right before or dialysis, LPN #2 stated yes, before the resident leaves for the ted the 11-7 shift completed the book but weights were shift. LPN #2 stated that early in the morning for the ted it appeared nursing was					
	documenting the we using a weight from #2 was shown the w (dialysis day) was from appeared daily weig completed. When a physician's order and	ight in the dialysis books the day before. When LPN eight recorded for 6/18/18, om 6/7/18; LPN #2 stated it hts were also not being sked if this was following the d comprehensive care plan,					
	determine why some the dialysis book, the PCC and the weight weight may have be LPN #2 confirmed sl communication form why she used the we p.m., LPN #6 stated	s not. LPN #2 could not e weights were missing from e vital signs section under logbook. LPN #2 stated the en done but not charted. The had filled out the dialysis on 6/20/18. When asked eight from 6/19/18 at 3:46 she guessed the order ecause she wasn't sure if the					

AND DIAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	· /	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 656	weight had to be right most recent weight? #2 could not recall weight? #2 could not recall weight. #2 could not recall weight. #3 could have a seen of 6/20/18. LPN #2 states at 8:20 at a conducted with CNA#1. When asked who weighing residents, and one nurse will weighing residents, and one nurse will record what the following of dialysis on Monday, stated a weight shour resident leaves for of did not work with Recurrently have any of order. On 6/22/18 at 8:25 at conducted with LPN checks meant on the and treatment, LPN a medication was act was provided. Whe sign off that a treatm when it in fact was not okay. When ask documenting that we when they were not, sure why because sup for the weight to stated that she hear weights. When ask if a resident refuses	nt before dialysis or just the has to be documented. LPN why she documented ote" on the June MAR for ated she has only worked with w days. LPN #2 stated that	F 65	56			

PRINTED: 07/20/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 656	followed if a resident weights, LPN #2 state on the care plan. LPI on his care plan that I on his care plan that I on 6/22/18 at 12:02 padministrator, ASM # Nursing), and ASM # Operations, were macconcerns. 5. The facility staff fai in place per the compressident #50. Resident #50 was ad 1/6/14 and readmitted that included but were diabetes, atrial fibrilla blood pressure. Resid (minimum data set) a assessment with an Adate) of 5/7/18. Resideng cognitively intacted cisions, scoring 12 Interview for Mental Swas coded as requirir one staff member for personal hygiene; and two plus staff member Review of Resident # that she had a fall on documented: "Found	note has to be sked about the process consistently refuses ed that it should be updated N #2 stated that it was not he refused weights. o.m., ASM #1, the 2, the DON (Director of 4, the Regional Director of de aware of the above led to ensure a fall mat was brehensive plan of care for mitted to the facility on don 4/13/18 with diagnoses enot limited to type two tion, heart failure, and high thent #50's most recent MDS assessment was an annual ARD (assessment reference dent #50 was coded as cot in the ability to make daily out of 15 on the BIMS (Brief Status) Exam. Resident #50 ng extensive assistance with bed mobility, toileting, and dextensive assistance from	F	356				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 656	24 BP (blood pressurextend R (right) leg ir in hip area. Physicial to send guest out at 4 daughter), notified an hospital). Transporte hospital) via (Name of transport] Service). " A fall assessment wa (three days) prior to to the Resident #50 as being Further review of the Resident #50 arrived 3/13/18 with a diagnoral Review of Resident #50 arrived 3/13/18 with	e is 124 RR (respirations) is e) is 134/92. Unable to n bed, c/o (complained) pain n notified and order received 1:10 p.m. Daughter (Name of d requests (Name of d at this time to (Name of ff EMT [emergency medical s completed on 3/6/18 he fall documenting g a low risk for falls. clinical record revealed that back to the facility on sis of a right hip fracture. 1:50's fall care plan revealed tion was initiated on 3/14/18 he care plan: "Mat to floor 1:50's admission he sment dated 3/13/18, he #50 as being a low risk for hall intervention was hing to be in place: "Fall Care hit to bed."	F	656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495394	B. WING				C 22/2018	
	ROVIDER OR SUPPLIER	,		9	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE SON AIR, VA 23235			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 656	6/21/18 at 5:00 p.m., bed with her bed up at There was no fall mat On 5/21/18 at 5:09 p conducted with CNA 2, Resident #50's CN know what intervention their residents to prethe CNAs receive ve CNA #2 also stated to care kardex, which so to follow. When asked if Resid down beside her bed hasn't had a fall mat asked how long CNA facility, CNA #2 stated the intervence of the conducted with LPN Resident #50's nurse #50 was a fall risk, Liffall on 3/9/18, she the least a low fall risk. Vis supposed to have stated she didn't thin communicated to CN fall prevention intervenurses verbally communicated on resident and update on resident and prevention intervenurses verbally communicated on resident and update on resident and prevention intervenurses verbally communicated on resident and prevention intervenurses verbally communicated on resident and prevention intervenurses verbally communicated on resident and prevention intervenues verbally communicated to CN fall prevention	Resident #50 was lying in against the right side of wall. It in place to the left side. I.m., an interview was (Certified nursing assistant) I.A. When asked how CNAs ons need to be in place for event falls, CNA #2 stated that ribal report from the nurses. That they could look at their erve as a guide for the aides and if Resident #50 was a fall that Resident #50 does not or her chair unassisted. The county is the county in the county in the county in the county is the county in the cou	F	656				

AND DI AN OF CORRECTION INTEREST IDENTIFICATION NUMBERS		1 ' '	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED		
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F 656	purpose was to ider and serve as a guid stated the care plan was o was important for the On 6/22/18 at 9:22 a conducted with LPN Resident #50's fall r LPN #3 stated Resiget out of bed, and be updated. On 6/22/18 at 11:19 conducted with ASN member) #2, the DO ASM #2 stated she intervention was an care plan because in the baseline care plan because in the baseline care plan was ever updated condition, on admission on 6/22/18 at 12:02 administrator, ASM Nursing), and ASM Operations, were moncerns. No furthe prior to exit. 6. The facility staff facomprehensive care ordered daily weight Resident #74 was a 5/24/18 with the diacongestive heart fai	care plan, LPN #3 stated the atify limitations, needs, goals, e for resident care. LPN#3 should be followed unless ut of date. LPN #3 stated it e care plan to be accurate. a.m., further interview was at 3. LPN #3 confirmed and was on the care plan. It dent #50 does not attempt to the care plan should probably a.m., an interview was at (administrative staff and (administrative st	F 65	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE SON AIR, VA 23235	1 00/	22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 656	attack. The most rec Set) was an admission (Assessment Referer resident was coded at to make daily life dec A review of the clinical dated 5/26/18 for "Dafor LVAD (Left ventric management. NOTIF GAIN OF 2 or MORE HOURS OR 4 OR MORE HOURS OR 4 OR MORE HOURS OR 4 OR MORE HOURS OR 5/26/18 for "Cardiac: A Output r/t (related to) HLD (hyperlipidemia) CAD (coronary artery heart failure), Paceminterventions included "Obtain weight and triphysician as needed. A review of the MAR Record) revealed that obtained on 6/8/18, 6 In addition, further retithe following: On 6/1/18 the resident w 2-pound weight gain on Weight obtain.	glaucoma, high blood ney disease, and a heart ent MDS (Minimum Data on assessment with an ARD nce Date) of 5/31/18. The is cognitively intact in ability isions. al record revealed an order nily weights in the morning rular assist device) FY PHYSICIAN IF WEIGHT LBS (pounds) IN 24 DRE LBS OVER 5 DAYS." blan revealed one dated at risk for decreased Cardiac at risk for decreased Cardiac by HTN (high blood pressure) at risk for decreased Cardiac by HTN (high blood pressure) by A-Fib (atrial fibrillation) by disease), CHF (congestive eaker" A review of the done dated 6/3/18 for eack changes, report to the " (Medication Administration to the were no weights by 11/18, 6/17/18, and 6/19/18. Wiew of the MAR revealed ent weighed 184.6. On by eighed 186.6. This was a	F	656				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495394	B. WING			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	<u> </u>	00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	the resident refused on 6/8/18. On 6/14/18, the refe/15/18, the residen 3.2-pound weight gase. On 6/17/18 and 6/19/18 and 6/19/19/19/19/19/19/19/19/19/19/19/19/19/	s. There was no evidence to have the weight obtained sident weighed 189.8. On the weighed 193. This was a sin in 1 day. 19/18 there were no weights subsequent weight the child date showed a weight loss eight. There was no evidence to have the weight obtained /18. In an interview with RN #4 when asked what staff do the one documented above, RN is should be obtained and if the MAR it most likely was not the importance of following atted that if the resident has in fluid and potentially could so.m., in an interview with LPN call Nurse), LPN #6 stated if the nents to obtain the weights not obtained, then the care add.	F 6	56		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION G	COMPLETED	
		495394	B. WING		C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 656	Continued From pag	ge 105	F 65	6	
	No further information the survey.	on was provided by the end of			
	7. The facility staff facomprehensive care for Resident #311.	ailed to follow the eplan to obtain daily weights			
	6/8/18 with diagnose limited to: infection of	admitted to the facility on es that included but were not of the hip, heart failure, diabetes, high blood y tract infection.			
	admission assessm reference date) of 6 having scored a 12 interview for mental	OS (minimum data set) an ent with an ARD (assessment /15/18 coded the resident as out of 15 on the brief status, indicating the resident aired to make daily decisions.			
	6/21/18, documente for decreased Cardi HTN (hypertension) irregular heartbeat), failure). Intervention	ent's care plan initiated on d, "Focus. CARDIAC: At risk ac Output R/T (related to): , A-Fib (atrial fibrillation an and CHF (congestive heart s. Obtain weight and track r medications as ordered."			
	documented, "daily	2018 physician's orders weight in the morning for chf ilure). Start Date: 6/12/18."			
	administration recor in the morning for cl to evidence docume	2018 TAR (treatment d) documented, "daily weight of." Review of the TAR failed entation of the resident's 8, 6/14, 6/15, 6/19 or 6/20/18.			

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		` ′	PLE CONSTRUCTION	COME	(X3) DATE SURVEY COMPLETED	
		495394	B. WING		I	C / 22/2018
	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00	122/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	Review of the vital s record did not evideresident's weight for Review of the nurse did not evidence doresident's weight. An interview was coa.m. with RN (regist manager. When ask record for the daily w"Maybe they're in the the weight book and name, there was not the dates document residents had care put they have care plans for the patient." When laske follow the care plans. An interview was cop.m. with LPN (licen When asked if there would not be followed it's endangering the On 6/22/18 at 12:10 staff member) #1, the director of nursing findings. No further information According to Fundar Williams and Wilkins weight of the patient of the pati	igns and weight summary noe documentation of the the above dates. Is notes for the dates above cumentation regarding the conducted on 6/21/18 at 11:57 ered nurse) #1, the unit led to review Resident #311's weights, RN #1 stated, eweight book." RN #1 got atturned to the resident's documentation of weights on led above. When asked why colans, RN #1 stated, "Why do les? So we know how to care en asked who used the care less asked who used the care l	F 65	56		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495394	B. WING _			C 06/22/2018	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	DE	00/22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIAT	DATE	
F 656	members that helps careThe nursing care information about the and goals. It contains achieving the goals of and is used to direct revise and update the there are changes in with new orders" (1) Fundamentals of & Wilkins 2007 Lippi pages 65-77. Basic Nursing, Esse (Potter and Perry, 20 reference for care pla a written guideline for promoting continuity criteria to be used in care. The written can ursing care prioritie professionals. The coordinates resource care. A correctly for easy to continue care if the patient's status nursing diagnosis and longer appropriate plan. An out of date compromises the quite statistics and the patient's staff facomprehensive care medications as orde #108.	emong health care team ensure continuity of are plan is a vital source of e patient's problems, needs, as detailed instructions for established for the patient careexpect to review, e care plan regularly, when condition, treatments, and 1) Nursing Lippincott Williams ncott Company Philadelphia Intials for Practice, 6th edition, 207, pages 119-127), was a ans. "A nursing care plan is or coordinating nursing care, of care and listing outcome the evaluation of nursing re plan communicates as to other health care care plan also identifies and as used to deliver nursing mulated care plan makes it as from one nurse to another. Thas changed and the defined related interventions are e, modify the nursing care or incorrect care plan ality of nursing care."	F 6	56			

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		l ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495394	B. WING		C 06/22/2018	
	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF BON AIR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 108 6/7/18 with diagnoses that included but were not limited to: diabetes, depression, high cholesterol, high blood pressure and heart disease. The most recent MDS (minimum data set) a five day assessment with an ARD (assessment reference date) of 6/14/18 coded the resident as scoring a 15 out of 15 on the brief interview for mental status. Resident #108 was coded as requiring staff assistance for activities of daily living except for eating which the resident could perform independently. A medication administration observation was made on 6/20/18 at 8:58 a.m. with LPN (licensed practical nurse) #7. LPN #7 took two Humalog insulin pens from the medication cart and set the dose to five units on one pen and eight units on the other pen. LPN #7 then went into Resident #108's room at approximately 9:03 a.m. and administered the insulin in the resident's right and left abdomen. The resident stated he had eaten breakfast around 8:30 a.m. Review of the care plan initiated on 6/13/18 documented, "Focus: At risk for fluctuation (sic) blood sugars R/T (related to): Diabetes. Interventions. Administer medication per order." Review of the June 2018 physician's orders documented, "HumaLOG (1) kwikPen Solution			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00/22/2010	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 656	6/7/18 with diagnos limited to: diabetes, high blood pressure. The most recent MI day assessment wir reference date) of 6 scoring a 15 out of mental status. Resirequiring staff assis living except for eat perform independer. A medication admir made on 6/20/18 at practical nurse) #7. insulin pens from the other pen. LPN #108's room at app administered the insuleft abdomen. The ribreakfast around 8: Review of the care documented, "Focublood sugars R/T (rinterventions. Admired the insuleft abdomen. The ribreakfast around 8: Review of the care documented, "Focublood sugars R/T (rinterventions. Admired the insuleft abdomen. The ribreakfast around 8: Review of the Care documented, "Focublood sugars R/T (rinterventions. Admired the June documented, "Hum 100 UNIT/ML (millilisubcutaneously bef HumaLOG KwikPetas per sliding scale - 220 = 4u; 221 - 26	es that included but were not depression, high cholesterol, and heart disease. DS (minimum data set) a five than ARD (assessment 6/14/18 coded the resident as 15 on the brief interview for dent #108 was coded as tance for activities of daily ing which the resident could ntly. Instration observation was 8:8:58 a.m. with LPN (licensed LPN #7 took two Humalog is medication cart and set the in one pen and eight units on #7 then went into Resident roximately 9:03 a.m. and sulin in the resident's right and resident stated he had eaten 30 a.m. plan initiated on 6/13/18 s: At risk for fluctuation (sic) elated to): Diabetes. inister medication per order." 2018 physician's orders aLOG (1) kwikPen Solution	F 65	6		

AND DUAN OF CODDECTION INDESTRUCTION NUMBER.		` '	PLE CONSTRUCTION G	(X3	COMPLETED		
		495394	B. WING _			C 06/22/2018	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		00/22/2018		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 656	administration recophysician's orders. documented as schithe resident at 7:30 and 8:00 p.m. An interview was cop.m. with LPN #7 at the unit manager. Vinedication could be have some leeway, away." When aske morning insulin was think it was 7:30 (a. recalled what times Resident #108 on Gresponse. When infoleon given a few mot have a response any consequence to hours late and after "I'm not sure." RN medication an hour ordered time." When administered the intimeframe, RN #1 stone of 6/22/18 at 12:10 staff member) #1, to the director of nursifindings. No further informations.	2018 MAR (medication rd) documented the above The medication was reduled for administration to a.m., 11:30 a.m., 5:30 p.m. 2018 MAR (medication rd) documented the above The medication was reduled for administration to a.m., 11:30 a.m., 5:30 p.m. 2018 MAR (registered nurse) #1, 2019 March (registered nurse) #1	F 6	56			
		failed to follow Resident #23's e plan for fluid restrictions.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495394	B. WING _			C 06/22/2018	
	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	E	33.22.23.13	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	Continued From pag	ge 110	F 6	56			
	2/28/18, with diagnorm not limited to: heart hyponatremia (Low bipolar disorder (a nunusual mood chan weakness. The most recent ME assessment, a quar ARD (assessment recoded the resident a (brief interview for mithat she had no cog A review of the com 3/5/18, with a most documented in part, and/or dehydration lappetitehyponatre restriction". In the lineed was documented an order than the production of the company of t	prehensive care plan dated recent revision on 3/12/18, "Need: At nutritional risk R/T (related to): decreased emia, diuretic use and fluid interventions section of this led in part, "Follow fluid					
	documented that Re ordered fluid amoun of 1600 cc, on 6/4/1	t #23's fluid intake report esident #23 exceeded the t on 6/2/18 with a fluid intake 8 with a fluid intake of 1400 with a fluid intake of 1540 cc.					
	nurse) #8, was aske	o.m., LPN (licensed practical and why residents have care and to improve care and for the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495394	B. WING			C / 22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00	22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 656	goal of discharge. We care plans, she state anything to do with the access to review the noted that "Care planensure the best quality on 6/21/18 at approx (registered nurse) #1 confirmed that the care RN #1 stated, "If the any interventions by restriction is exceeded following the care plane ASM #1 (the administrations of nursing), ASM #4, operations), and ASM coordinator) were material concern on 6/22/18 at a concern on 6/22/18 at anything the state of th	work towards the common then asked who uses the d, "Anybody who has be person's care should have care plan". She further as need to be accurate to try of care". Simately 4:15 a.m., RN was asked how it could be re plan is being followed. In the staff when the fluid and, then the staff is not sin". It trator), ASM #2, (the director (the regional director of M #5 (the regional clinical and aware of the above	F 68	56		
F 657 SS=D	(1) This information following website: https://medlineplus.g (2) This information following website: https://medlineplus.g Care Plan Timing and CFR(s): 483.21(b)(2) §483.21(b) Compreh §483.21(b)(2) A combe-	was obtained from the ov/ency/article/000394.htm was obtained from the ov/bipolardisorder.html d Revision (i)-(iii) ensive Care Plans prehensive care plan must 7 days after completion of	F 65	57		8/3/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495394	B. WING _		0	C 6/ 22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	•	06/22/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 657	includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and the resident and their An explanation must medical record if the and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and rev team after each asse comprehensive and c assessments. This REQUIREMENT by: Based on observation interview, facility doc record review, it was failed to review and rev	terdisciplinary team, that nited to ysician. e with responsibility for the responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident presentative is determined to development of the e staff or professionals in ined by the resident's needs to resident. ised by the interdisciplinary sament, including both the quarterly review This is not met as evidenced on, resident interview, staff tument review and clinical determined the facility staff the evise the comprehensive is residents in the survey 3.	F 6	<u> </u>	liance with		
	Resident #23's comp reflect her noncompli fluid restrictions. The findings include:	rehensive care plan to ance with physician ordered		DON/Designee regarding upd comprehensive care plans for restriction non- compliance. DON/Designee during mornin meeting to conduct quality mo- resident non-compliance of flu	lating fluid g clinical onitoring of uid		
	Resident #23 was ad	mitted to the facility on		restrictions, 5x week x1 week	, then		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495394	B. WING			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235)DE	00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 657	2/28/18, with diagnos not limited to: heart d hyponatremia (Low sibipolar disorder (a me unusual mood change weakness. The most recent MDS assessment, a quarte ARD (assessment refeoded the resident as (brief interview for me that she had no cogn coded as always und always making herse was coded as requiring one or more staff mentransfers, toileting, and A review of the composition of the c	es that included but were isease, high blood pressure, odium level in the blood) (1), ental illness which includes es) (2), and muscle 6 (minimum data set) erly assessment, with an iference date) of 4/4/18, is scoring a 15 on the BIMS ental status) score, indicating tive impairment. She was erstanding others and if understood. Resident #23 and extensive assistance of mbers for bed mobility, and personal hygiene. The ensive care plan dated excent revision on 3/12/18, Need: At nutritional risk of (T (related to): decreased mia, diuretic use and fluid erventions section of this d in part, "Follow fluid d".	F 6	weekly x4 weeks and then nand as indicated. Findings to be communicate committee monthly and as in Quality monitoring schedule based on findings.	ed to the QA ndicated.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495394	B. WING_			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	I	06/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 657	conducted with Res was aware of a physiliad intake she stated the numerous unopubedside table, Resid I could drink as man because they [the sasked who told her "The staff." When a explained to her wh sodas in her daily flustated, "No An interview was cop.m. with CNA (certic CNA #4 was asked recorded on the dail the fluids from the ramount the nurses genetications. When the daily fluid intake stated, "Yes, we tell they tell us the amounded together into shown the June inta and was asked aborestriction was exceresident sneaks soccommunicated to the "Yes." On 6/21/18 at 2:25 pronducted with LPN LPN #7 confirmed the communicate with each of the CNAs know how receives when taking the conducted with the CNAs know how receives when taking the conducted with the cname the conducted with the cname the cname that the cname t	a.m., an interview was ident #23. When asked if she sician's order restricting her ed "Yes." When asked about ened soda cans on her ident #23 stated, "They told me by of those as I wanted odas] don't count." When this, Resident #23 responded sked if the staff had by she needed to count the uid intake, Resident #23. Inducted on 6/21/18 at 2:20 fied nursing assistant) #4. Exactly what fluids are by intake report. She stated esident's food trays and any give the resident with asked if she communicated as to the nurses CNA #4 the nurses the amount, then unt from medications, and it is the report." CNA #4 was ke report for Resident #23 at the days where the fluid eded. CNA #4 stated, "The as". When asked if this was e nurses, CNA #4 stated. D.m., an interview was (licensed practical nurse) #7.	F 6	57		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495394	B. WING_			C 6/22/2018		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		00/22/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 657	document it. LPN #7 #23's name] has bee restriction many time #23's noncompliance nursing notes or in th LPN #7 stated she di A review of the nurse 6/20/18 failed to docu interventions were pr regarding her noncor ordered fluid restriction On 6/21/18 at 3:28 p. nurse) #8 was asked plans. She stated to staff and resident to sta	further stated, "[Resident n noncompliant with her fluid s." When asked if Resident was documented in the e comprehensive care plan, d not know. 's notes from 6/1/18 to ument any education or ovided to Resident #23 inpliance with the physician on. Im., LPN (licensed practical why residents have care improve care and for the work towards the common then asked who uses the d, "Anybody who has be person's care should have care plan." LPN #8 further is need to be accurate to the ty of care." When asked it be revised, LPN #8 stated, change in condition."	F6	57				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495394	B. WING _		C 06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	30.22.20.0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	D.4TE	
F 657	"Lots of things, like fareasons to update a cresidents noncomplia ASM #2 stated, "Yes, planned as it is perso include education about following M.D.'s (medical ASM #1 (the administ of nursing), ASM #4, operations), and ASM coordinator) were maconcern on 6/22/18 at No further information (1) This information (1) This information (2) This information (3) This information (4) This information (5) This information (6) This information (7) The services Provided Medical ASM 21(b)(3) Compressives Pro	n is revised, ASM #2 stated lls. There are a lot of lare plan." When asked if a nce would be care planned, noncompliance should care n centered and should out consequences of not ical doctor's) orders." rator), ASM #2, (the director (the regional director of l #5 (the regional clinical de aware of the above t 12:02 p.m. I was provided prior to exit. I was obtained from the ov/ency/article/000394.htm vas obtained from the ov/bipolardisorder.html eet Professional Standards ii) ehensive Care Plans d or arranged by the facility, inprehensive care plan,	F 6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495394	B. WING _			06/2	; 22/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	I CODE	00/2	.2/2010	
				9101 BON AIR CROSSINGS DRIVE				
THE LAUF	RELS OF BON AIR			BON AIR, VA 23235				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIA	I .	(X5) COMPLETION DATE	
F 658	Continued From pag	ge 117	F 6	558				
F 038	sample, Resident #3 and 105. 1. The facility staff for order to change the Resident #311. 2. The facility staff for sugar on four occas Resident #308. 3 a. The facility staff parameters for as not medication administ. 3 b. The facility staff the topical pain medication administered for Resident #308 administered for Resident #308.	ailed to clarify a physician's intravenous dressing for ailed to document the blood ions in June 2018 for affailed to clarify the eeded narcotic pain ration for Resident #108.	F 6	and location of resident's p #50s blood sugars are beir and addressed as per MD Resident #6s weights are to and documented as per Pr Resident #6s pain medicat clarified. Resident #74 no in this facility. Resident #6 resides in this facility. Res longer resides in this facility #105 no longer resides in th All residents have the pote affected. The DON/designee to educ staff on ensuring orders are intravenous dressing chan are being obtained/docume weight gain are reported to as per Physician order, blo being monitored, documen interventions are being folli Physician orders and pain are ordered with paramete DON/designee during more meeting to conduct quality	ng monitored order. being obtaine hysician orde tion has been longer reside 7 no longer sident #1s no by. Resident this facility. Ential to be cate nursing e in place for ges, weights ented and or the Physicial bod sugars around as per medications ers. ning clinical	ed er. n ess		
	dialysis. 5 b. The facility staff Resident #6's daily	were documenting that weights were completed on , when they were not		week x1 weeks, weekly x4 monthly, PRN and indicate	and then			
	5 c. The facility staff	failed to clarify three as deres for pain medication for						
	6. The facility staff t	ailed to follow professional						

PRINTED: 07/20/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495394	B. WING			C 06/22/2018		
	ROVIDER OR SUPPLIER	40004	1	9·	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE SON AIR, VA 23235	J 06/.	22/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 658	of the physician of Re 2 or more pounds in 2 pounds in 5 days per 7. The facility staff fai order for Resident #6 Lidocaine {1} gel 2% 8. The facility staff fa orders for as needed for Resident #1. 9. The facility staff fa orders for as needed Resident #105. The findings include: 1. Resident #311 was 6/8/18 with diagnoses limited to: infection of irregular heart beat, or pressure and urinary The most recent MDS admission assessment reference date) of 6/1 having scored a 12 or interview for mental swas moderately impared of Resident #311. The alert and sitting up or resident's wife was all	enting physician notification esident #74's weight gain of 24 hours or 4 or more physician's order. led to clarify the physician's 7 for the administration of to labia. illed to clarify the physician's Dilaudid (3) pain medication ailed to clarify the physician's pain medication for s admitted to the facility on a that included but were not the hip, heart failure, liabetes, high blood tract infection. 6 (minimum data set) an nt with an ARD (assessment 5/18 coded the resident as	F	858				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495394	B. WING			C
	ROVIDER OR SUPPLIER	433334		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		06/22/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 658	was covered with a could be seen on the dressing had been of admitted to the facility wife both said it had. Review of the reside initiated on 6/8/18 de PICC Line dressing. Review of the June documented, "PICC was no frequency de decumented, "PICC was no frequency de decumented for the PICC the upper left corner labeled Unschedule dressing change" was decumented about the a resident had a PIC clean the IV port with syringe, and check fewhen the PICC line #2 stated, "Our proteriest I'm going to chareviewed the resider like the order was proposed to chareviewed the June 2 (treatment administres "There's nothing the	nis right upper arm, which transparent dressing. No date e dressing. When asked if the changed since he was ty, Resident #311 and his not. ent's baseline care plan ocumented, "Infection Alert. (change) per order." 2018 physician's orders line dressing change." There ocumented. 2018 MAR (medication d) did not evidence a commented. 2018 MAR was a box d "Other" Orders. "PICC line as documented in the box. Inducted on 6/21/18 at 11:35 seed practical nurse) #2. he process staff follows when complete the process staff fol	F 65	58		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495394	B. WING _			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 658	Continued From pa	ge 120	F 6	58		
	the doctors want it of every seven days." PICC line dressing I admission, LPN #2 since there was no document it.	ow often he wants it; some of lone every five days or some When asked if the resident's nad been changed since stated she did not think it had schedule and no place to				
	p.m. with LPN (licen nurse who cared for about the process s had a PICC line, LP them you make sure the dressing gets ch needed." When ask changed, LPN #8 st When asked if she h	anducted on 6/21/18 at 12:40 ased practical nurse) #8, a the resident. When asked taff follows when a resident N #8 stated, "When you get e it's patent (functional). I think hanged once a week or as ed why the dressing was ated, "To avoid infection." had changed Resident #311's since admission, LPN #8				
	staff member) #1, the director of nursing findings. ASM #2 wastandards the facility "Lippincott and our page 1.5 member)	p.m. ASM (administrative ne administrator and ASM #2, ng were made aware of the as asked what professional y used, ASM #2 stated, policies." A request was made ne for a policy on clarifying				
	Practice", Eighth Ed Wilkins, pg. 15, the part, "Inappropriate cannot automaticall unsafe, you cannot either. b Call the your concerns with	cott Manual Of Nursing lition: by Lippincott Williams & following is documented in Orders: 2. Although you y follow an order you think is just ignore a medical order, attending physician, discuss him, obtain c. Notify all involved medical				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495394	B. WING			C 06/22/2018
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	I	06/22/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 658	On 6/22/18 at 2:35 p nursing from an affili have a policy on clar Review of the facility Venous Catheter (C' not evidence docum the physician's order No further information 1. PICC A device of treatments, including blood transfusions. A into a vein in the upp (threaded) into a large the heart called the sis inserted into a por blood or give fluids. weeks or months an repeated needle stick inserted central cath obtained from: https://www.cancer.gancer-terms/def/picco 2. The facility staff fa sugar on four occasi Resident #308 was a 6/6/18 with diagnose limited to: irregular h failure, high blood pr	in the interest of a state of a s	F 6:	58		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	'	33.22.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 658	Continued From pag	ue 122	F 6	58		
	the resident as havir the brief interview fo	nce date) of 7/13/18 coded ng scored a 14 out of 15 on r mental status indicating the vely intact to make daily				
	6/13/18 documented (sic) blood sugars R	#308's care plan initiated on I, "Need. At risk for fluctuation /T (related to): Diabetes. ister medications per orders.				
	Review of the June 2018 physician's orders documented, "CHECK BLOOD SUGAR AC (before meals) and HS (bedtime) before meals and at bedtime for DM2 (diabetes mellitus type 2 [1])."					
	"CHECK BLOOD SU HS (bedtime) before DM2." Review of the documentation of the	2018 MAR documented, JGAR AC (before meals) and meals and at bedtime for e MAR did not evidence e resident's blood sugar on 6/12/18 at 6:30 a.m., 6/13/18 19/18 at 6:30 a.m.				
	summary form did no	nt's weights and vitals of evidence documentation of the dates documented above.				
		otes for Resident #308, did entation of the blood sugars ented above.				
	p.m. with LPN (licens LPN #2. When asked MAR meant, LPN #3	nducted on 6/22/18 at 2:01 sed practical nurse) #3 and d what blank spaces on the 3 stated, "Looking at it, it er done or they forgot to				

AND BLAN OF CORRECTION IDENTIFICATION NUMBER		PLE CONSTRUCTION G	[` '			
		495394	B. WING			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	<u> </u>	06/22/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 658	document blood sug "Because you want stable. How would y document it, you do hypoglycemic (low land)." On 6/22/18 at 12:10 staff member) #1, the the director of nursi findings. ASM #2 w standards the facilit "Lippincott and our According to "Lippi Practice", Eighth Ed Wilkins, Chapter 25 "Blood Glucose Mo determination of ca patients in the contradiabetes mellitus. Be evaluate effectivened glucose ecursion af response to exercise evaluation of episod hyperglycemia to do treatment." No further information.	asked if it was important to gars, LPN #2 stated, to know if the patient is you know if you don't on't know if they're blood sugar) or hyperglycemic on p.m. ASM (administrative the administrator and ASM #2, ang were made aware of the as asked what professional yoused, ASM #2 stated, policies." Incott Manual Of Nursing dition: by Lippincott Williams & Join Diabetes Mellitus, pg. 912,	F 6	58		
	Insulin is a hormone your cells to give the too much glucose s	es not make or use insulin well. e that helps glucose get into em energy. Without insulin, tays in your blood. Over time, can lead to serious problems				

STATEMENT OF AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		DATE SURVEY COMPLETED
		495394	B. WING			C 06/22/2018
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	I	00/22/2010
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	and teeth. This infor https://medlineplus.g This information was website: https://medlineplus.g 3 a. The facility staff parameters for as not medication administ. Resident #108 was 6/6/18 with diagnose limited to: fractured anemia, depression There was not compset) at the time of th nurse's comprehens documented, that th time, place and persodocumented as need activities of daily living. Review of the reside 6/7/18 documented, (related to): impaired Administer medication effectiveness effects physician." Review of the June adocumented, "Hydro Tablet 5-325 MG (mouth every 4 hours	s, kidneys, nerves, and gums mation was obtained from: gov/diabetestype2.html (3) is obtained from the following gov/ency/article/003481.htm If failed to clarify the eeded narcotic pain ration for Resident #108. admitted to the facility on es that included but were not leg, bacterial infection, and high blood pressure. Seleted MDS (minimum data e survey. Review of the sive evaluation dated 6/6/18 e resident was oriented to son. The resident was ding assistance from staff for	F 68	58		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495394	B. WING _			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	<u>'</u>	33,22,2313
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 658	being administered 6/10, 6/12, 6/13, 6/13 occasions for pain rarespectively. The tw documented as beint three occasions, 6/8 three occasions, 6/13 two occasions and 6 resident's pain level 8, 8, 5, 5, 8, 8, 9, 7, 7 respectively. An interview was coa.m. with LPN (licen When asked about to determining which pwhen the resident has take." When asked orders for hydrocodd documented, LPN # why the medication asked if it was in the determine at what pbe given, LPN #2 did An interview was cop.m. with LPN (licen When asked about to a resident has two a dosages ordered, LI time I rate their pain or two pills. If I feel I them the option. If the time I rate their pain or two pills. If I feel I them the option. If the second occasions of the pain or two pills. If I feel I them the option. If the second occasions of the pain or two pills. If I feel I them the option. If the pain or two pills. If I feel I them the option. If the pain occasions occasions of the pain occasions of the pain occasions of the pain occasions of the pain occasions occasions of the two pains occasions of the pain occasions occasions of the two occasions of the pain occasions occasions of the two occasions occasions of the two occasions occasion	blet dose was documented as on 6/7 on two occasions, 6 and 6/17/18 on two atings of 5, 3, 4, 7, 3, 4, 5, 5 or tablet dose was a gadministered on 6/7, 6/8 on a on four occasions, 6/10 on 1 on three occasions, 6/12 on on three occasions, 6/14 on 6/15/18 on two occasions. The was documented as being, 5, 8, 5, 5, 4, 4, 4, 4, 4, 3, 6, and and and the documented on 6/21/18 at 11:35 seed practical nurse) #2. The process staff follows when ain medication to administer as two as needed pain ordered, LPN #2 stated, the pain level, I would leave it is to which one they want to to review Resident #109's one and the pain levels 2 didn't have an answer for was given as it was. When a nurse's scope of practice to ain level a medication would	F 6	58		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495394	B. WING				22/2018
	ROVIDER OR SUPPLIER		•	9101	EET ADDRESS, CITY, STATE, ZIP CODE BON AIR CROSSINGS DRIVE I AIR, VA 23235		
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F 658	been giving." On 6/22/18 at 12:10 p staff member) #1, the the director of nursing findings. ASM #2 was standards the facility "Lippincott and our portion of the facility "Lippincott and our portion of the facility "Lippincott and our portion of the facility "MANAGEMENT PRO" "Purpose: The Pain Note of the Pain Note of the Pain Note of the Pain Note of the Condition of the facility of the facility of the provide the nursing stapproach for develop for pain management effectiveness of the condocumentation regmedication paramete. According to "Lippinc Practice", Eighth Edit Wilkins, pg. 87 read: dosages or unfamilian confirmed with the helpharmacist before ad following is document Orders: 2. Although yfollow an order you the just ignore a medical attending physician, ohim, obtain appropriation involved medical and Document clearly." No further information 1. Hydrocodone is a standard provided medical and Document clearly."	c.m. ASM (administrative administrator and ASM #2, gowere made aware of the asked what professional used, ASM #2 stated, plicies." Is policy titled, "PAIN DOGRAM" documented, Management Program will taff with a structured ing an appropriate care plant, and/or to evaluate the urrent regimen." There was garding clarifying pain	F	558			

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495394	B. WING			C 06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	'	00/22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 658	of acute or chronic pantihistamines or an cough. Hydrocodon to serum enzyme electinically apparent liwith acetaminophen cases of acute liver overdose with aceta was obtained from: https://livertox.nih.go. 3 b. The facility staff the topical pain mediadministered for Research Review of the June administered for Research Review of the June administration record Gel 1% Apply 1 app times a day for pain. Review of the June administration record Gel 1% Apply 1 app times a day for pain documented for when the medication was applied every day. An interview was coa.m. with LPN (licen When asked what we medication order, LF right dose, right time route." When asked where a topical pain	is widely used for treatment pain, and in combination with ticholinergics used to treat e by itself has not been linked evations during therapy or to per injury, but the combination has been linked to many failure due to unintentional minophen. This information has been linked to many failure due to unintentional minophen. This information has been linked to clarify the location of ication was to be sident #108. 2018 physician's orders ten (1) Gel 1% Apply 1 mally four times a day for location documented for	F 68	58			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
		495394	B. WING _			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	DE	00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BI E APPROPRIA	
F 658	review Resident #10 LPN #2 stated, "Wel let's start right there stated, "It doesn't te An interview was co p.m. with LPN #8, th asked to review the LPN #8 stated, "It's probably say the loc location should be in stated yes. When as clarified the order wi stated yes. On 6/22/18 at 12:10 staff member) #1, th the director of nursin findings. According to "Lippin Practice", Eighth Ed Wilkins, pg. 87 read dosages or unfamilia confirmed with the h pharmacist before a following is documed Orders: 2. Although follow an order you i just ignore a medica attending physician, him, obtain appropri involved medical and Document clearly." No further information 1. Voltaren gel Vo	l9's order for Voltaren gel, I it needs to be clarified so " When asked why, LPN #2	F6	558		

495394 B. WING	C 06/22/2018
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF BON AIR STREET ADDRESS, C 9101 BON AIR CROS BON AIR, VA 2323	CITY, STATE, ZIP CODE SSINGS DRIVE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH C	VIDER'S PLAN OF CORRECTION (X5) CORRECTIVE ACTION SHOULD BE EFFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 658 Continued From page 129 amenable to topical treatment, such as the knees and those of the hands. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/druglnfo.cf m?setid=b04009ca-7545-4cd4-af63-f15aebf20f18 4. The facility staff failed to evidence that an intervention was implemented when Resident #50's blood sugar reading was at a level of 50 on 4/6/18. Resident #50 was admitted to the facility on 1/6/14 and readmitted on 4/13/18 with diagnoses that included but were not limited to type two diabetes, atrial fibrillation, heart failure, and high blood pressure. Resident #50's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 5/7/18. Resident #50 was coded as being cognitively intact in the ability to make daily decisions, scoring 12 out of 15 on the BIMS (Brief Interview for Mental Status) Exam. Resident #50 was coded as requiring extensive assistance with with one staff member for bed mobility, toileting, and personal hygiene; and extensive assistance from two plus staff members for transfers. Review of Resident #50's April 2018 POS (physician order summary) revealed that she received Humalog (1) sliding scale insulin. The following order was documented: "Humalog KwikPen Solution Pen-Injector 100 Unit/ML (milliliter) (insulin lispro) Inject per sliding scale: If 141-180=4 units 181-220=6 units	

AND DIAN OF CORRECTION IDENTIFICATION NUMBER			PLE CONSTRUCTION G	l(X	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	ı	06/22/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 658	301-350 = 12 units 351-400 = 16 units 40 MD (medical doctor), meals and at bedtime Review of Resident # (medication administ on 4/6/18 at 11:30 a. There was no eviden notified of this low ble evidence that the nur place to increase her Further review of Res report revealed that s percent of her lunch a Review of Resident # that on 4/6/18 at 4:37 sugar had risen to 80 #50's blood sugar dre fifteen minutes later I unresponsive due to 32. There was evide notified at this time o unresponsiveness de increase the blood su Review of Resident # dated 3/14/18, docur SU (sugar): At risk fo R/T (related/to) Diabe free from signs of col blood sugars such as changesobserve al	and or greater 16 units and call subcutaneously before for DM (diabetes mellitus)." 250's April 2018 MAR ration record) revealed that m., her blood sugar was 50. ce that the physician was bood sugar. There was no ise had put an intervention in blood sugar. 250's mursing notes revealed that m. her blood sugar. 250's nursing notes revealed to p.m., Resident #50's blood to At 4:45 p.m., Resident poped down to 70 and then resident #50 was her blood sugar dropping to note that the physician was for Resident #50's espite intervention to agar. 250's diabetes care plant mented the following: "Blood in fluctuation blood sugars etes. Goal: Guest will be implications from fluctuation is mental status and document s/sx ications from fluctuating	F 6	58		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION		TE SURVEY MPLETED
		495394	B. WING		,	C 06/22/2018
THE LAURELS OF BON AIR		STREET ADDRESS, CITY, STATE, ZIP COI 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	REET ADDRESS, CITY, STATE, ZIP CODE 01 BON AIR CROSSINGS DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 658	conducted with LPN the nurse who worked 4/6/18 at 11:30 a.m. considered a low blook it depended on the pashe considered hypomanything under 60." process if a resident LPN #4 stated that is the resident juice to sugar, monitor the resident juice to sugar, monitor the resident juice to sugar, monitor the resident functions, LPN # stated that she would interventions, LPN # stated that she would interventions in a nurshe would notify the reading of 50, LPN # definitely make sure gone up." When ask Glucagon (3), LPN # glucagon only if the glucagon. LPN #4 is standing order and is physician to obtain a was familiar with Resident #50's blook 4/6/18 at 11:30 a.m., could not remember the initials on the MA record) were hers, Li asked if the physicial low blood sugar read 4/6/18, LPN #4 state should have docume	Im., an interview was (licensed practical nurse) #4, and with Resident #50 on When asked what she od sugar, LPN #4 stated that atient. When asked what adjucemic (2), LPN #4 stated, When asked the nursing were to be hypoglycemic, he would immediately give bring it up, recheck the blood asident closely, and then agar again in thirty minutes. yould document these 4 stated, "Yes." LPN #4	F 65	58		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		TE SURVEY MPLETED
		495394	B. WING		١,	C
	ROVIDER OR SUPPLIER	100007	STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		06/22/2018	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 658	#4 stated, "Maybe the LPN #4 stated that it she would stop and When asked how this would know what was LPN #4 stated, "You that her sugar was 50 On 6/21/18 at 1:32 periodicted with LPN considered hypoglyce "Anything below 60." she were to have a relevel of below 60, LF provide the resident crackers with peanuf would check on their stated that if food into would notify the MD glucagon and admin would still notify the episode. LPN #3 stated that happened to the that she would always that were put into play made aware in a numerous would know in place for a low blood was notified if there clinical record, LPN shave put it on the 24 that if the nurse did it report than there was was done.	n intervention in place. LPN ne 50 was a miscoding?" if a blood sugar was that low call the MD (medical doctor). Is writer and other nurses as done for Resident #50, Imean to tell me I recorded if a mean to tell me I recorded if a blood sugar if a mean to tell me I recorded if a blood sugar if a mean to tell me I recorded if a blood sugar if a mean to tell me I recorded if a blood sugar if a mean to tell me I recorded if a blood sugar if a bl	F6	58		
	-	staff member) #2, the DON				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495394	B. WING				22/2018
	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE 3ON AIR, VA 23235	1 007	22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	report was presented box was completely by Was Completely by On 6/21/18 at 1:56 p. conducted with ASM ASM #3 could not red Resident #50's low by that she probably wo monitor and maybe a stated that a blood suconsidered hypoglyces he would first expect recheck in an hour ar ASM #3 that she would here aware of any hy stated that nursing stated that a blood sugars will nurse or a qualified must nurse nurse nurse n	imately 2 p.m., the 24-hour for 4/6/18. The 7-3 shift blank. m., an interview was #3, the nurse practitioner. call being made aware of ood sugar. ASM #3 stated uld have given an order to dminister glucagon. ASM #3 agar reading under 70 was emic. ASM #3 stated that the nursing to give juice, and hold any ordered insulin. Ild expect nursing to make poglycemic event. ASM #3 aff may have notified her but hent. D.m., ASM #1, the 2, the DON (Director of 4, the Regional Director of de aware of the above as asked what professional used, ASM #2 stated,	F	358			

PRINTED: 07/20/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495394	B. WING				22/2018
	ROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE SON AIR, VA 23235	1 06/1	22/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	physician notification date and time of notification date and time of notification of the progression of the	e physician, as directed. If is necessary, document ication and the physician's ress notes. spro protamine and insulin of a fast-acting insulin and g type of human insulin. The pile with diabetes to help els under control. This ned from The National of the National of the pile with diabetes to help els under control. This ned from The National of	F	358			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		495394	B. WING		C 06/22/2018	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00/22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
F 658	Institutes of Health. https://www.niddk.ni etes/overview/preve cose-hypoglycemia. (3) Glucagon injecticused to treat severe sugar) in diabetes probtained from The Nhttps://www.ncbi.nlmT0010481/?report=0 5 a. The facility staff Resident #6's weigh dialysis when then with dialysis. Resident #6 was add 12/6/17 with diagnost limited to end stage type two diabetes are pulmonary disease). MDS (minimum data quarterly assessment reference date) of 3/c coded as being cognmake daily decisions 15 on the BIMS (Bridexam. Review of Resident summary) dated 6/1 following orders: "W Monday, Wednesda initiated on 1/12/18. record-report gain of the summary gain of the summ	h.gov/health-information/diab nting-problems/low-blood-glu on is an emergency medicine hypoglycemia (low blood atients. This information was lational Institutes of Health.	F 65	8		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495394	B. WING			l	0
NAME OF D	ROVIDER OR SUPPLIER	40004	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	22/2018
NAIVIE OF PI	ROVIDER OR SUPPLIER						
THE LAUF	RELS OF BON AIR				9101 BON AIR CROSSINGS DRIVE		
				ŀ	BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	week one time a day was initiated on 4/13/ Review of Resident # 3/19/18 documented a "Obtain daily weights to dialysis sessions." Review of Resident # (medication administrates Resident #6 has had days: 6/1/18 6/4/18 6/6/18 6/8/18 6/11/18 6/13/18 6/15/18	for heart failure." This order 18. 6's Renal Care Plan dated the following intervention: as ordered as well as prior 6's June 2018 MAR ation record) revealed that dialysis on the following umented that Resident #6 at. d 6/18/18; a check mark he MAR indicating that btained prior to dialysis. A d not be found in the clinical 6/4/18 could not be found on kept at the nursing station. ication form for 6/4/18 could	F	658			
	6/6/18 was not prior to	o dialysis. The weight was at 11:20 a.m. The following					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495394	B. WING		06/22/2018	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	00/22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLET	
F 658	Review of the dialys 6/18/18 revealed tha 6/18/18 was not prior recorded was from 6 following was docum 6/7/18 at 139 p.m." Further review of the resident was docum home" on the following 6/11/18, and 6/15/18 Weights for 6/8/18, 6 not be found in the cof the clinical record was coded as being because he was at a dialysis communicat 6/11/18 and 6/15/18 that the weights wer dialysis. Further review of the blank or hole for the weight could not be weight could not be at the nursing station communication form blank for weight, ind not obtained prior to Review of the June 2 following documents Nurse/Note." Review	is communication form dated at the weight documented for ir to dialysis. The weight 6/7/18 at 1:39 p.m. The mented: "Weight 128.6, date B. June MAR revealed that the ented as being "Absent from ing dialysis days: "6/8/18, 3." 6/11/18, and 6/15/18 could elinical record. Further review revealed that Resident #6 "Absent from home" dialysis. Review of the ion form dated 6/8/18, revealed blanks indicating in not obtained prior to B. June 2018 MAR revealed a dialysis day 6/13/18. A found in the clinical record. A found on the weight log kept in Review of dialysis dated 6/13/18 revealed a dicating that the weight was	F 65	58		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		495394	B. WING			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		00/22/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 658	Continued From pag	ge 138	F 6	58		
	conducted with Res that the facility staff percent of the time. On 6/21/18 at 12:31 conducted with LPN Resident #6's nurse the following order r dialysis on Monday, stated that weights dialysis. When askethe resident leave for it meant for that day dialysis. LPN #2 stathe dialysis forms in obtained by the day Resident #6 leaves dialysis. LPN #2 stathe dialysis forms in obtained by the day Resident #6 leaves dialysis. LPN #2 stathe dialysis day) was frappeared daily weight growpleted. When a physician's order and LPN #2 stated, it was determine why som the dialysis book, th PCC and the weight weight may have be LPN #2 confirmed sommunication form why she used the wp.m., LPN #6 stated	p.m., an interview was ident #6. Resident #6 stated checked his weight about 50 p.m., an interview was (licensed practical nurse) #2, that shift. When asked what neant: "Weight prior to Wednesday, Friday," LPN #2 should be obtained prior to ed if that meant right before or dialysis, LPN #2 stated yes, before the resident leaves for ted the 11-7 shift completed the book but weights were shift. LPN #2 stated that early in the morning for ated it appeared nursing was eight in the dialysis books the day before. When LPN reight recorded for 6/18/18, om 6/7/18; LPN #2 stated it hts were also not being sked if this was following the d comprehensive care plan, as not. LPN #2 could not be weights were missing from the vital signs section under a logbook. LPN #2 stated the len done but not charted. The he had filled out the dialysis on 6/20/18. When asked eight from 6/19/18 at 3:46 she guessed the order				
	weight had to be rig	ecause she wasn't sure if the ht before dialysis or just the has to be documented. LPN				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495394	B. WING		06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	06/22/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 658	"Hold/See nurses no 6/20/18. LPN #2 sta Resident #6 for a fer she was new at the On 6/22/18 at 8:20 a conducted with CNA#1. When asked wh weighing residents, and one nurse will weighing residents, and one nurse will record what the following or dialysis on Monday, stated a weight shour resident leaves for or did not work with Recurrently have any of order. On 6/22/18 at 8:25 a conducted with LPN checks meant on the and treatment, LPN a medication was accomposed. Whe sign off that a treatment when it in fact was mot okay. When ask documenting that we when they were not, sure why because sup for the weight to stated that she hear weights. When ask if a resident refuses the MD (medical documenting and a nursing lead of the stated and a nursing stated that she hear weights. When ask if a resident refuses the MD (medical documenting and a nursing lead of the stated and a nursing lead of the stated that she hear weights. When ask if a resident refuses the MD (medical documenting and a nursing lead of the stated and a nursing lead of the stated that she hear weights. When ask if a resident refuses the MD (medical documenting and a nursing lead of the stated that she hear weights. When ask if a resident refuses the MD (medical documenting and a nursing lead of the stated that she hear weights.)	why she documented of the on the June MAR for atted she has only worked with w days. LPN #2 stated that facility. a.m., an interview was a (certified nursing assistant) no was responsible for CNA #1 stated that two aides weight a resident together and the weight. When asked order meant: "Weight prior to Wednesday, Friday," CNA #1 all be obtained before the dialysis. CNA #1 stated she esident #6, and did not dialysis patients with that kind a.m., further interview was #2. When asked what the end MAR under a medication #2 stated that checks meant diministered or a treatment on asked if it was ever okay to the net/medication was given tot, LPN #2 stated that it was seed why nurses were eights were being completed LPN #2 stated she wasn't the thought a window popped to the thought a window popped t	F 65	8	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495394	B. WING _			C 06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		1 00/22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	weights, LPN #2 sta on the care plan. LI on his care plan tha On 6/22/18 at 12:02 staff member) #1, th DON (Director of No Regional Director of aware of the above 5 b. The facility staff Resident #6's daily the June 2018 MAR obtained daily. Review of Resident summary) dated 6/1 following order: "Da record- report gain of 24 hours or < (less states time a day for heart initiated on 4/13/18. Review of June 201 Administration Reco check marks, indical on the following day	t consistently refuses ted that it should be updated PN #2 stated that it was not the refused weights. p.m., ASM (administrative te administrator, ASM #2, the trising), and ASM #4, the troperations, were made concerns. were documenting that weights were completed on the weights were not #6's POS (physician order /18, documented the tily Weights- obtain and tof > (greater) than 3 pounds in than) 5 lbs in one week one failure." This order was 8 MAR (medication tod) for Resident #6, revealed ting a weight was obtained, s: 6/2/18, 6/4/18, 6/5/18, 8, 6/10/18, 6/12/18, 6/14/18,	F 6	58			
	the clinical record fo	ordings could not be found in ir to following dates: 6/2/18, 1/18, 6/12/18, 6/14/18, 6/17/18,					
		e June 2018 MAR revealed a ined on 6/8/18, 6/11/18, and					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	' '	DATE SURVEY COMPLETED	
		495394	B. WING			C 06/22/2018	
	ROVIDER OR SUPPLIER	10000		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 658	from home." Review revealed Resident # dates. A weight sho another physician's dialysis. The June 2018 MAF blank space for 6/13 indicating why a we Lastly, the June 201 following for 6/20/18 note could not be fo was not obtained fo Review of Resident 3/19/18 did not addit Resident #6's renal documented the foll daily weights as well conducted with Resident #6's nurse that the facility staff percent of the time. On 6/21/18 at 12:31 conducted with LPN Resident #6's nurse weights were condustated if weights could click care), they may on the unit. This work book with LPN #2 for Resident #6 were appeared that daily completed. When a	ing was documented: "Absent of the clinical record to was at dialysis on these ould have been obtained per order to check weight prior to the clinical and the control of t	F 6:	58			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	' '	ATE SURVEY DMPLETED
		495394	B. WING			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	I	00/22/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 658	determine why some the vital signs section book. LPN #2 then been done but not conshe was the nurse won 6/20/18. LPN #2 documented "Hold/S MAR for 6/20/18. LI worked with Resider stated that she was On 6/22/18 at 8:20 acconducted with CNA#1. When asked who weighing residents, and one nurse will worked with LPN checks meant on the and treatment, LPN a medication was acconducted with LPN checks meant on the and treatment, LPN a medication was acconducted. Whe sign off that a treatment when it in fact was mot okay. When asked documenting that we when they were not, sure why because sup for the weight to stated that she hear weights. When asked the process if a residuant a nursing note it is stated that the MD and a nursing note it is stated that the MD and a nursing note it is stated that the MD and an ursing note it is stated that the MD and an ursing note it is stated that the MD and a nursing note it is stated that the MD and an ursing note it is stated that the MD and an ursing note it is stated that the MD and an ursing note it is stated that the MD and an ursing note it is stated that the MD and an ursing note it is stated that the MD and an ursing note it is stated that the MD and an ursing note it is stated that the MD and an ursing note it is stated that the MD and an ursing note it is stated that the MD and an ursing note it is stated that the MD and an ursing note it is stated that the MD and an ursing note it is stated that the MD and an ursing note it is stated that the MD and it is stated that the MD and an ursing note it is stated that the MD and an ursing note it is stated that the MD and an ursing note it is stated that the MD and an ursing note it is stated that the MD and under the unit is stated that the MD and under the unit is stated that the MD and under the unit is stated that the MD and under the unit is stated that the unit	it was not. LPN #2 could not be weights were missing from in PCC and in the weight stated the weights may have harted. LPN #2 confirmed who worked with Resident #6 could not recall why she see nurses note" on the June PN #2 stated she has only int #6 for a few days. LPN #2 new to the facility. a.m., an interview was a (certified nursing assistant) no was responsible for CNA #1 stated that two aides weigh a resident together and the weight. CNA #1 stated k with Resident #6. a.m., further interview was #2. When asked what the e MAR under a medication #2 stated that checks meant diministered or a treatment in asked if it was ever okay to nent/medication was given not, LPN #2 stated that it was seed why nurses were eights were being completed LPN #2 stated she wasn't the thought a window popped be entered in PCC. LPN #2 d that Resident #6 refused	F 65	58		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	' '	DATE SURVEY COMPLETED	
		495394	B. WING _			C 06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		00/22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	Continued From pag	ge 143	F 6	58			
	updated on the care was not on his care was not on his care On 6/22/18 at 9:20 a conducted by teleph who signed off on the was obtained on 6/8 #6. When asked the weights, LPN #1 state monitor for fluid over check marks meant stated that checks in medication/treatment asked where daily we LPN #1 stated daily the clinical record; upor in a nursing note. okay to document a it was not obtained, never okay to document a it was not obtained, never okay to documented a daily Resident #6 on 6/9/ was not recorded in stated, "My CNAs gigo." LPN #1 then him on 6/22/18 at 12:02 staff member) #1, the DON (Director of No Regional Director of Regional Director of states).	nt was administered. When weights were documented, weights were documented in order the vital sign tab in PCC. When asked if it was ever weight was completed when LPN #1 stated that it was ment something was done asked why she weight was completed for 18 and 6/10/18 if a weight the clinical record, LPN #1 et weights for me. I have to ung up the phone. p.m., ASM (administrative and administrator, ASM #2, the arsing), and ASM #4, the coperations, were made concerns. No further					
	_	failed to clarify three as deres for pain medication for					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495394	B. WING		C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 658	Continued From pa	ge 144	F 65	8	
	Review of Resident order summary) dat following orders: "Tylenol (1) 500 mg by mouth as needed Norco Tablet (2) 7.5 mouth every 8 hours. Tramadol (3) HCL (tablet every 8 hours. Review of Resident (medication administing he did not receive Turther review of the received Norco on to 6/1/18 at 3:02 a.m. 6/2/18 at 9:24 a.m. of 6, 6/3/18 at 5:42 a.m. p.m. for a pain level 6/4/18 at 1:31 a.m.	#6's June POS (physician led 6/1/18, documented the (milligrams): Give 2 caplets d for pain three times daily. If mg/325 mg; Give 1 tablet by so as needed for pain. The sas needed that sas needed that following at all that month. The same pain level of 4, and 6:17 p.m. for a pain level for a pain level of 8 and 4:10			
	6/5/18 at 5:29 a.m. 6/6/18 at 6:08 a.m. p.m. for a pain level 6/7/18 at 7:54 a.m. p.m. for a pain level 6/8/18 at 5:34 a.m. 6/9/18 at 6:01 a.m. p.m. for a pain level 6/10/18 at 1:12 a.m 6/11/18 at 5:03 a.m 6/12/18 at 2:37 a.m	for a pain level of 5 and 5:12 l of 6, for a pain level of 8 and 5:35 l of 2, for a pain level of 4, for a pain level of 8 and 2:14 l of 9, . for a pain level of 4, . for a pain level of 2, . for a pain level of 8, . for a pain level of 8, . for a pain level of 4,			

PRINTED: 07/20/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495394	B. WING				22/2018
	ROVIDER OR SUPPLIER		•	9	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	p.m. for a pain level of 6/16/18 at 8:09 a.m. for a pain 6/17/18 at 5:37 a.m. for a pain level of 10:18 p.m. for a pain level of p.m. for a pain level of 12. for a pain level of 12. for a pain level of 13. for a pain level of 14. for a pain level of 14. for a pain level of 15. for a pain level of 16. for a pain level	for a pain level of 8 and 3:30 of 5, for a pain level of 6 and level of 5, for a pain level of 4, at 12:52 of 4 and 9:01 p.m. for a pain level of 2, for a pain level of 8. O18 MAR revealed that Tramadol on the following at 9:37 p.m., 6/3/18 at 8:56 as a.m. all for a pain level of 6, and 10:45 a.m. for a pain level of 10:45 a.m. for a pain level of 2, for a pain level of 5, for a pain level of 5, for a pain level of 6, for a pain level of 8, for a pain level of 3. In specified on when to give 1. The specified on when to give 1. The specified on when to give 1. The specified on when to give 1.	F	658			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495394	B. WING				22/2018
	ROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 0011	22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	administered, LPN ### the resident's pain. A #6's pain medication. Resident #6 decides wants when. When a for a pain level of 2, I nursing staff should r the MD (medical doc- each prn medication. #6) orders need to ha On 6/22/18 at 12:02 staff member) #1, the DON (Director of Nur Regional Director of aware of the above of The facility policy title Program" did not add According to "Lippino Practice", Eighth Edit Wilkins, pg. 87 read: dosages or unfamilia confirmed with the he pharmacist before act following is documen Orders: 2. Although y follow an order you th just ignore a medical attending physician, whim, obtain appropria involved medical and Document clearly." (1) Tylenol Tablet (Act aches and pains and	en each medication should be 2 stated that it depended on When asked about Resident LPN #2 stated that which pain medication he asked why Norco was given LPN #2 stated that the really get clarification from tor) on when to administer LPN # stated his (Resident ave parameters. p.m., ASM (administrative en administrator, ASM #2, the resing), and ASM #4, the Operations, were made	F	658			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED	
		495394	B. WING			C 6/22/2018	
	ROVIDER OR SUPPLIER	10001		STREET ADDRESS, CITY, STATE, ZIP CO 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	•	1 06/22/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 658	T0008785/?report=0 (2) Norco (Hydrococcombination is used moderately severe properties of Health. https://www.ncbi.nlm. T0010590/?report=0 (3) Tramadol is an amoderate to severe obtained from Davis 11th edition p. 1197. 6. The facility staff fistandards for docum of the physician of R2 or more pounds in pounds in 5 days per Resident #74 was ac 5/24/18 with the diagcongestive heart fail pulmonary disease, heel pressure ulcer, pressure, chronic kid attack. The most reset) was an admissi (Assessment Refere resident was coded to make daily life derequired total care for assistance for transf hygiene; supervision incontinent of bowel	n.nih.gov/pubmedhealth/PMH letails. done and acetaminophen) to relieve moderate to vain. Narcotic pain reliever. s obtained from The National n.nih.gov/pubmedhealth/PMH letails. nalgesic used to treat pain. This information was by Drug Guide for Nurses, ailed to follow professional menting physician notification desident #74's weight gain of 24 hours or 4 or more rephysician's order. Idmitted to the facility on gnoses of but not limited to ure, chronic obstructive atrial fibrillation, diabetes, left glaucoma, high blood diney disease, and a heart cent MDS (Minimum Data on assessment with an ARD ence Date) of 5/31/18. The as cognitively intact in ability cisions. The resident or bathing; extensive fers, dressing, toileting, and in for eating; and was	F 65	58			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		COMPLETED
		495394	B. WING			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 658	GAIN OF 2 or MORHOURS OR 4 OR MAIRecord) revealed the obtained on 6/8/18, In addition, further of the following: On 6/1/18, the resident 2-pound weight gain evidence the physician. On 6/7/18, the resident weight gain in 2 day the physician was rand of the weight gain. On 6/14/18, the resident yeight gain in 2 day the physician was rand of the weight gain. On 6/14/18, the resident 3.2-pound weight gain. On 6/17/18, and 6 and no evidence the subsequent weight showed a weight lo There was no docuphysician was notificobtained.	icular assist device) ITFY PHYSICIAN IF WEIGHT RE LBS (pounds) IN 24 MORE LBS OVER 5 DAYS." R (Medication Administration nat there were no weights 6/11/18, 6/17/18, and 6/19/18. review of the MAR revealed sident weighed 184.6. On weighed 186.6. This was a n in 24 hours. There was no cian was notified of the weight sident weighed 185.2. There ined on 6/8/18. On 6/9/18, the 92.6. This was a 7.4-pound ys. There was no evidence notified of the missed weight,	F 65	58		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495394	B. WING			C 6/ 22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	•	0/22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 658	concerns. On 6/21/18 at 11:12, (Registered Nurse), volumes do with an order above, she stated that provider. She stated MAR it most likely was the doctor should have asked the importance #4 stated that if the retaining fluid and posissues. On 6/22/18 at 9:36 a. #1, she stated, the nearly should document that When asked the reas and notifying the doctor can ensure resident is weighted as weight gain." RN # should document that When asked the reas and notifying the doctor can ensure resident is the following that the state of the st	in an interview with RN #4 when asked what should the er like the one documented at the expectation is to notify that if weights are not on the as not done. RN #4 stated we been notified. When e of following this order, RN esident has CHF she is tentially could have a lot of m., in an interview with RN urse is to make sure the and call the doctor if there is et stated that the nurse to the doctor was called. Son for checking the weights tor, RN #1 stated, "So the sident is well." In an interview with ASM #3 Member, the nurse estated that she "feels 99.9% excause the nurse is on top of very morning about 7:30 If she is not symptomatic, I ssarily order something." If policy, "Physician and date that the physician sician's response, and any	F 6	58			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		495394	B. WING			C 06/22/2018
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	I	00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 658	Administrator) and Nursing) were mad	age 150 0 p.m., ASM #1 (the ASM #2 (the Director of e aware of the findings. ion was provided by the end of	F 65	58		
	order for Resident: Lidocaine {1} gel 2' Resident #67 was a 5/7/18 with the diag hematuria, neuroge spasms, dorsalgia, pressure, anxiety d most recent MDS (admission/5-day as (Assessment Refer resident was coded ability to make daily was coded as havin bladder function. A review of the clin dated 6/3/18 for "Li topically every 4 hours) A review of the Jun Administration Rec was administered of a.m.	admitted to the facility on gnoses of but not limited to enic bladder, diabetes, muscle dementia, high blood isorder, and depression. The Minimum Data Set) was an essessment with an ARD rence Date) of 5/14/18. The das being cognitively intact in y life decisions. The resident an indwelling catheter for docaine {1} gel 2% to labia ours as needed for pain. Apply and PRN (as needed)." The e 2018 MAR (Medication ord) revealed the medication only once, on 6/20/18 at 1:57				
	administer only PR	ence of an order clarification to N, or only every 4 hours very 4 hours scheduled and as				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE SURVEY COMPLETED
		495394	B. WING		C 06/22/2018
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235 ID PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	1 00/22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION
F 658	#1 (Registered Nurse is confused about an but that her interprets should be scheduled as-needed. In review she stated based on order, the MAR is mi hour administration pPRN administration practitioner), she star intended to be only ppe scheduled for everon 6/22/18 at 12:30 staff member) #1 (the Director of Nursi findings. No further in the end of the survey According to "Lipping Practice", Eighth Edi Wilkins, pg. 87 read: dosages or unfamilia confirmed with the hepharmacist before act following is document Orders: 2. Although yfollow an order you the just ignore a medical attending physician, him, obtain appropria involved medical and Document clearly."	a.m., in an interview with RN e), she stated that if a nurse order, they should clarify it, ation of the order is that it every four hours and ving the MAR with RN #1, her interpretation of the ssing a schedule for every 4 biece, and only reflects the biece of the order. a.m., in an interview with ive Staff Member, the nurse ted that the order was PRN, and was not intended to ary 4 hours. p.m., ASM (administrative e Administrator) and ASM #2 ng) were made aware of the information was provided by	F 658		

PRINTED: 07/20/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495394	B. WING				C 22/2018
	ROVIDER OR SUPPLIER	,	,	9	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE SON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	signals in your body. on the skin) is used to caused by skin irritation bites, poison ivy, poison minor cuts, scratches is also used to treat in hemorrhoids. Information obtained https://www.drugs.co. 8. The facility staff factorders for as needed for Resident #1. Resident #1 was adm 6/15/18, with diagnost not limited to: low back (spine surgery on the which damaged bone heart disease, diabet pulmonary disease (amakes it hard to breat anxiety, and severe contact the most recent MDS assessment, a five dawith an assessment in coded the resident as (brief interview for methat she had no cognicoded as always und always making herse was coded as requirimobility, transfers, to hygiene. The physician order of the contact of the physician order of the contact of the physician order of the physician). It works by blocking nerve Lidocaine topical (for use o reduce pain or discomfort ons such as sunburn, insect son oak, poison sumac, and s, or burns. Lidocaine topical ectal discomfort caused by from m/mtm/lidocaine-topical.html tiled to clarify the physician's Dilaudid (3) pain medication nitted to the facility on ses that included but were ck pain, L3-L5 Laminectomy elumbar 3-5 vertebra in es or disks are removed) (1), es, chronic obstructive a chronic lung disease that ith) (2), high blood pressure,	F	658			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPLETED
		495394	B. WING		C 06/22/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	33.22.20.0
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 658	tablet 2 mg (milligra 6 hours for pain E by mouth every 3 h pain." The "as need to document what " should be used baselevel. The June 2018 MA physician orders. The documented as have 6/19/18 at 10:45 p.1. The baseline care produmented in particomfortable as postioned documented in particomfortable as postioned as a local medications as ordered. An interview was conurse) #1 on 6/21/1 how it is determined how she assesses stated, "We ask the the pain they are had determine which pacognitively impaired assess for facial grimoaning". When a as noted in the abo "We need to ask the pain means." ASM (administrative administrator, ASM ASM #4, the region	im): give 4 mg by mouth every bilaudid tablet 2 mg: give 4 mg ours as needed for severe edded" order for Dilaudid failed severe pain" is or when it died on the resident's pain. R documented the above the "as needed" Dilaudid was ving been administered on m. for a pain level of 6. Dolan, dated 6/15/18, "Goal: Guest will be as sible." The "Interventions", "observe for pain and report catedAdminister pain	F 658	3	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		С	
		495394	B. WING_			06/	22/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF BON AIR				101 BON AIR CROSSINGS DRIVE		
				E	BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page 12:02 p.m. According to "Lippinco Practice", Eighth Editi Wilkins, pg. 87 read: dosages or unfamiliar confirmed with the he pharmacist before adrifollowing is document Orders: 2. Although y follow an order you th just ignore a medical attending physician, ohim, obtain appropriatinvolved medical and Document clearly." No further information w following website:	ott Manual Of Nursing ion: by Lippincott Williams & "Nursing Alert: Unusual drugs should always be alth care provider and ministration." On pg. 15, the led in part, "Inappropriate ou cannot automatically ink is unsafe, you cannot order, either. b Call the discuss your concerns with teorders. c. Notify all nursing personnel d. In was provided prior to exit.	TAG	658	DEFICIENCY)	TE.	DATE
	(2) This information w	ov/ency/article/007389.htm ras obtained from the					
	following website: https://medlineplus.go	ov/ency/article/000091.htm					
	(3) This information w following website: https://medlineplus.go ml	vas obtained from the ov/druginfo/meds/a601148.ht					
	9. The facility staff fa orders for as needed Resident #105.	ailed to clarify the physician's pain medication for					
	Resident #105 was ac	dmitted to the facility on					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	COMPLETED
		495394	B. WING		C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 658	5/23/18, with diagnor not limited to: fracture urine, high blood proportion and heart disease. The most recent MI assessment, a 14 dwith an assessment (brief interview for not that she had no cogcoded as always unalways making hers #105 was coded as assistance of one of mobility, transfers, thygiene. The physician order "Oxycodone HCI (htere is in the image) by mouth every Give two or one tab for Oxycodone faile where to determine should be administed based on the resided The June 2018 MAI physician orders. The was documented as 6/2/18 at 6:49 p.m. at 7:26 p.m. for a pain level p.m. for a pain level documentation indicate received one or two	Deses that included but were ared right shoulder, retention of dessure, muscle weakness, DS (minimum data set) ay Medicare assessment, a reference date of 6/4/18, as scoring a "13" on the BIMS mental status) score, indicating unitive impairment. She was aderstanding others and delf understood. Resident requiring extensive are more persons for bed oileting, bathing, and personal of dated, 5/23/18, documented, ydrochloride): Give 2 tablet are document how staff whether one or two tablets dered or when it should be used ent's pain level. R documented the above me "as needed" Oxycodone is having been administered on for a pain level of 7; on 6/3/18 at level of 4; on 6/16/18 at 7:06 of 7 and on 6/17/18 at 1:23 of 6. There was no cating whether the resident	F 658		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
				_		(c
		495394	B. WING _			06/	22/2018
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUR	RELS OF BON AIR			9	101 BON AIR CROSSINGS DRIVE		
				В	SON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	documented in part, "recent fall with fractur The "Interventions" do "Administer medicatic effectiveness/side effectiveness to phy characteristics of pair description scale: mild An interview was connurse) #1 on 6/21/18 how it is determined higiven to a resident whorder for one or two task them the pain lev they are having. That two or one, we need to which level of pain rectablets." ASM (administrative sadministrator, ASM #4, the regional ASM #5, the regional made aware of the ab 12:02 p.m.	Need: Actual pain related to ed right proximal humerus." poumented in part, on for pain and observe for ects and report resicianevaluate at on scale of 0-10 or verballed, moderate, severe". Iducted with RN (registered at 2:35 p.m. When asked now much pain medication is men the resident has an ablets, RN #1 stated, "We ell or to number the pain at order should not say give to ask the doctor to clarify equires which number of staff member), #1, the 2, the director of nursing, director of operations, and clinical coordinator, were nove concern on 6/22/18 at sing" 8th edition, 2013:	F	358			
		Anne Griffin Perry: Mosby, 43-13 Nursing Principles for sics".					
F 684 SS=E	Quality of Care	n was provided prior to exit.	F	684			8/3/18
	§ 483.25 Quality of ca Quality of care is a ful	are ndamental principle that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED		
		495394	B. WING			C 06/22/2018		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		0.012.010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PREFIX	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	facility residents. Bas assessment of a resi that residents receive accordance with prof practice, the comprecare plan, and the re This REQUIREMENT by: Based on observation record review, and fawas determined that ensure residents recoin accordance with practice and the compartice and the comparti	nt and care provided to sed on the comprehensive dent, the facility must ensure extreatment and care in ressional standards of hensive person-centered sidents' choices. To is not met as evidenced on, staff interview, clinical acility document review, it the facility staff failed to eived treatment and services refessional standards of prehensive person-centered of prehensive person-centered of residents in the survey residents in the survey residents in the survey resident #74's daily weights. The service of the comprehensive person-centered of the survey residents in the survey residents in the survey resident #74's daily weights. The service of the comprehensive person-centered of the survey residents in the survey residents in the survey resident #74's daily weights.	F 68	Resident #74 no longer resider facility. Resident #108 no longer this facility. Resident #311 is resident medications and daily weights at the Physician. Resident #309s is in place and functioning as per Physician order. Resident #102 intake is documented as per Physician order. Resident #6s weights and obtained and documented as per Physician order. All residents have the potential affected. The DON/designee to educate staff on following Physician order staff on following Physician order obtaining and documenting weight administering medications incluinsuling as per Physician order, operation and function as per Forder and documentation of fluid DON/designee during morning meeting to conduct quality morning meeting to conduct quality morning week x1 weeks, weekly x4 and monthly, PRN and indicated. Findings to be communicated to committee monthly and as indic Quality monitoring schedules measured to the second of the property o	er resides in eceiving as order by wound vacuer 2s fluid hysician's e being er to be nursing lers for ights, uding wound care Physician id intake. clinical hitoring 5x then o the QA cated.			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495394	B. WING _			C 06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	<u> </u>	3072272010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	Continued From pa	_	F 6	84			
	6. The facility staff f per physician's orde	ailed to obtain daily weights er for Resident #6.					
	The findings include	: :					
		failed to follow physician's Resident #74's daily weights.					
	5/24/18 with the dia congestive heart fai pulmonary disease, heel pressure ulcer, pressure, chronic ki attack. The most re Set) was an admiss (Assessment Refere	idmitted to the facility on gnoses of but not limited to lure, chronic obstructive atrial fibrillation, diabetes, left glaucoma, high blood dney disease, and a heart ecent MDS (Minimum Data ion assessment with an ARD ence Date) of 5/31/18. The as cognitively intact in ability ecisions.					
	dated 5/26/18 for "E for LVAD (left ventri management. NOT GAIN OF 2 or MOR	cal record revealed an order Daily weights in the morning cular assist device) TIFY PHYSICIAN IF WEIGHT E LBS (pounds) IN 24 MORE LBS OVER 5 DAYS."					
	Record) revealed th	R (Medication Administration at there were no weights 6/11/18, 6/17/18, and 6/19/18.					
	In addition, further r the following:	eview of the MAR revealed					
	was no weight obtainesident weighed 19 weight gain in 2 day	sident weighed 185.2. There ined on 6/8/18. On 6/9/18, the 92.6. This was a 7.4-pound vs. There was no documented cian was notified of the weight					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495394	B. WING		C 06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00/22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 684	and no evidence the subsequent weight showed a weight los. There was no document of the physician was notified. On 6/21/18 at 11:12 #4 (Registered Nursare not on the MAR record) it most likely the importance of fostated if the resident fluid and potentially. On 6/22/18 at 9:36 #1, she stated, the resident is weighed a weight gain." 6/22/18 10:55 a.m., (Administrative Staf practitioner), she stated them and calls me expression of the care (AM) to update me. am not going to need the care (A)/18 for "Cardiac: Output r/t (related to HLD (hyperlipidemia CAD (coronary arter)	_	F 684	1		

	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495394	B. WING			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	·	06/22/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	Nursing) were made facility policy for folk requested via a list of the facility. No furth by the end of the su 2. The facility staff facordered by the physical Resident #108 was	p.m., ASM #1 (the ASM #2 (the Director of aware of the findings. A bwing physician's orders was of policies needed provided to er information was provided	F 68	34		
	The most recent ME day assessment with reference date) of 6, scoring a 15 out of 1 mental status. Residence during staff assist	OS (minimum data set) a five the an ARD (assessment 14/18 coded the resident as 15 on the brief interview for lent #108 was coded as ance for activities of daily ng which the resident could				
	made on 6/20/18 at practical nurse) #7. insulin pens from the dose to five units on the other pen. LPN a #108's room at appradministered the insleft abdomen. The rebreakfast around 8:3	istration observation was 8:58 a.m. with LPN (licensed LPN #7 took two Humalog e medication cart and set the one pen and eight units on #7 then went into Resident oximately 9:03 a.m. and sulin in the resident's right and esident stated he had eaten 30 a.m. Dian initiated on 6/13/18 sc. At risk for fluctuation (sic)				

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495394	B. WING				22/2018
	ROVIDER OR SUPPLIER		'	٤	STREET ADDRESS, CITY, STATE, ZIP CODE 0101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 684	Review of the June 2 documented, "Humal 100 UNIT/ML (millilite subcutaneously befo HumaLOG KwikPen as per sliding scale: i - 220 = 4u; 221 - 260 350 =10u; 351 - 400 md (medical doctor) skin) before meals ar (diabetes mellitus)." Review of the June 2 administration record physician's orders. The documented as schethe resident at 7:30 at and 8:00 p.m. An interview was comp.m. with LPN #7 and the unit manager. When the unit manager. When the unit manager. When dication could be have some leeway. When asked morning insulin was think it was 7:30 (a.m. recalled what time should be supposed. When info been given a few min not have a response any consequence to hours late and after the "I'm not sure." RN #*	ister medication per order." 2018 physician's orders LOG (1) kwikPen Solution er) Inject 5 unit re meals for diabetes. Solution 100 unit/ML inject f 141 - 180 = 2u (units); 181 re 6u; 261 - 300 = 8u; 301 - re 14u; 401 - 402 = 14u call subcutaneously (below the re at bedtime for dm 2018 MAR (medication re) documented the above re medication was duled for administration to re.m., 11:30 a.m., 5:30 p.m. aducted on 6/21/18 at 12:18 re RN (registered nurse) #1, ren asked what time frame a regiven, LPN #7 stated, "We re expected to give it right when Resident #108's re be given, LPN #7 stated, I re.)." When asked if she re gave the insulin to 20/18, LPN #7 didn't have a rmed the medication had re given, LPN #7 did re was giving insulin one and a half oreakfast, LPN #7 stated, it stated, "They can give refore and an hour after the	F	684			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495394	B. WING				22/2018
	ROVIDER OR SUPPLIER	1	1	9	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 001	22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	timeframe, RN #1 sta On 6/22/18 at 12:10 staff member) #1, the the director of nursin findings. No further information 3a. The facility staff the medications as order Resident #311. Resident #311 was at 6/8/18 with diagnose limited to: infection of irregular heart beat, pressure and urinary The most recent MD admission assessment reference date) of 6/1 having scored a 12 of interview for mental swas moderately impart Review of Resident splan initiated on 6/21 CARDIAC: At risk for R/T (related to): HTN fibrillation an irregulation (congestive heart fail Administer medication Review of the physical documented, "Amiood documented, "Am	ulin within the correct ated she had not. p.m. ASM (administrative e administrator and ASM #2, g were made aware of the an was provided prior to exit. failed to administer red by the physician for admitted to the facility on as that included but were not at the hip, heart failure, diabetes, high blood a tract infection. S (minimum data set) an ent with an ARD (assessment 15/18 coded the resident as but of 15 on the brief status, indicating the resident aired to make daily decisions. #311's comprehensive care 1/18 documented, "Focus. or decreased Cardiac Output IV (hypertension), A-Fib (atrial ular heartbeat), and CHF lure). Interventions.	F	684			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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F 684	an irregular heartbead Metoprolol Succinate mouth one time a day Start Date: 06/09/2018 by mouth two times at Date: 06/09/2018. Mit mouth. Start Date: 06 mg give by mouth. St Spironolactone (6) 25 one time a day for He 06/08/2018." Review of the June 2 administration record HCL Tablet 200 MG (mouth one time a day an irregular heartbead On 6/9/18, a "5" and documented. "Metoprolol Succinate one time a day for HD Date: 06/09/2018." "Keppra Give 500 mg for Seizures. Start Data "5" and the nurse's 9:00 a.m. and 5:00 p. "Midrodine 5 mg Give 06/09/2018." On 6/9 and 8:00 p.m. and on 1:00 p.m. a "5" and the documented. "Oxybutynin 2.5 mg give 100 mg 1:00 p.m. a "5" and the documented.	of for AFIB (atrial fibrillation t). Start Date: 06/09/2018. XL (2) Give 100 mg by of or HTN (hypertension). 8. Keppra (3) Give 500 mg of day for Seizures. Start drodine (4) 5 mg Give by of object of the start of the sta	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		495394	B. WING _			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	CODE	00/22/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 684	p.m. and on 6/10/18 a "5" and the nurse's in "Spironolactone 25 m one time a day for He 06/08/2018." On 6/9 "5" and the nurse's in Review of the chart of documented, "5= Hol Review of the nurse's "6/9/2018 15:10 (3:10 medication administration Note. MG Give 1 tablet by AFIB. Awaiting pharm 6/9/18 15:13 (3:13 p. Administration Note. Give 100 mg by mour Awaiting pharmacy; 6/9/18 15:13 eMar (e administration record Note. Metoprolol Sucmouth one time a day pharmacy; 6/9/18 15:13 eMar (e administration record Note. Midrodine 5mg pharmacy; 6/9/18 15:14 eMar (e	at 9:00 a.m. and 5:00 p.m. a itials were documented. Ing Give 1 tablet by mouth eart Failure. Start Date and 6/10/18 at 9:00 a.m., a itials were documented. Index of the MAR documented. Index of the MAR documented of the MAR documented. Index of the MAR documented of the MAR docume	F	584		
) - Medication Administration mg Give by mouth. Awaiting				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	TE SURVEY MPLETED			
		495394	B. WING			C)6/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	administration recorn Note. Spironolacton mouth one time a dapharmacy." An interview was coa.m. with LPN (licenturse who documer unavailable. When a obtained for new adwhen I get the admit (the medications) asked what staff dowere not available, I the pharmacy. I can that night." When as notified, LPN #1 stated in the pharmacy. I can that night. When as notified, LPN #1 stated in the pharmacy. I can that night. When as notified, LPN #1 stated in the pharmacy. I can that night. When as notified, LPN #1 stated in the pharmacy. I can that night. When as notified, LPN #1 stated in the pharmacy. I can that night. When as notified, LPN #1 stated in the pharmacy. I can that night. When as notified, LPN #1 stated in the pharmacy. I don't know how to machine. I didn't have either."	electronic medication d) - Medication Administration e 25 mg Give 1 tablet by ay for Heart Failure. Awaiting Inducted on 6/22/18 at 9:17 Ised practical nurse) #1, the Ited the medications as Isked how medications are Inducted on 6/22/18 at 9:19 Istated, "So, Ission when the order is put in Istated, "I usually call the remember if I called them Isked if anyone else would be Ited, "No." When asked if the Istated, "I usually call the remember if I called them Isked if anyone else would be Ited, "No." When asked if the Istated, take medications out of the Istated about the process staff	F 68	34		
	with the physician. To computer and the plus next run. When ask pharmacy to deliver stated, "It depends can pull medications dispensing machine (immediate) box that supplies." When ask	cations for a new cated, "They verify the orders Then they enter them into the narmacy delivers them on the ed how long it would take the the medication, RN #1 on the admission time. We from the (name of mediation) and we have a stat thas IV (intravenous) are down staff accessed the ng machine, RN #1 stated,				

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495394	B. WING		C 06/22/2018
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 684	use it in so many dipharmacy came in When asked if staff medications availal medication-dispens "She (LPN #1) shorthose medications. notify the physician A telephone intervicat 9:29 a.m. with O Pharmacist. When sending medication stated, "They are loa.m. to 10:00 p.m. send the medication asked if the facility medications, OSM A telephone intervicat 9:32 a.m. with O support. When ask medications, OSM several medications orders that were incompleted that time. An interview was conducted and interview w	code. I heard that if you don't ays it expires. I know the and put in new pass codes." were expected to obtain ole from the sing machine, RN#1 stated, and have been able to obtain If staff can't get them they	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495394	B. WING _			C 06/22/2018		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 9101 BON AIR CROSSINGS DRIV BON AIR, VA 23235		00/22/2010		
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F 684	it's six to eight hours. medication-dispensin to pull it from there. It dispensing machine) see if he wants to chat today and start it the Review of the pharmadocumented, "Proof of Date Shipment Summar Shipped, 6/8/18. Date PM. LEVETIRACETA TABLET. QTY (quantification of the pharmadocumented, "Proof of Date Shipment Summar Shipped, 6/8/18. Date PM. LEVETIRACETA TABLET. QTY (quantification of the pharmadocuments of the medications with the director of the medication of the medication of the medication of the medication of the physical contents of the physical of the ph	inda hard to say. Normally We have a (name of the g machine) and we're able it's not in the (medication I have to call the doctor and ange the order or hold it for next day." acy manifest dated 6/8/18 of Delivery - Shipment Detail. hary. (Name of facility). Date e Received: 6/8/18 10:34 M (Keppra) 1000MG ity) 8. LEVETIRACETAM QTY 4. METOPROLOL OMG. QTY (quantity) 2. 200MG TABLET. QTY. 2." ere documented as not the pharmacy on 6/9/18. ation dispensing machine nted, "AMIODARONE HCL OH (quantity on hand) 10. C (succinate) ER (extended LET. QOH 10. Ceppra) MG. QOH 10. 25 MG. QOH 10." These ailable for administration as	F	584				
		clearly linked to several						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495394	B. WING		06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	33,22,23,13
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERSON OF THE APPROPRIES OF	JLD BE COMPLETION
F 684	information was ob https://livertox.nih.g 2. Metoprolol is a c that is widely used hypertension and a been linked to rare injury. This informa https://livertox.nih.g 3. KEPPRA is indic the treatment of pa and children 1 mon epilepsy. This inforhttps://dailymed.nlr	arg induced liver disease. This tained from: gov/Amiodarone.htm ardioselective beta-blocker in the treatment of angina pectoris. Metoprolol has cases of drug induced liver tion was obtained from:	F 68	4	
	for the treatment of hypotension (OH). hydrochloride table of supine blood pre systolic), it should the are considerably in clinical care, includit treatment (such as expansion, and life information was obhttps://dailymed.nlrm?setid=4c3517f3-1 5. Oxybutynin chlorare a muscarinic ar treatment of overact urge urinary inconti	chloride tablets are indicated symptomatic orthostatic Because midodrine ts can cause marked elevation essure (BP>200 mmHg be used in patients whose lives apaired despite standard ing non-pharmacologic support stockings), fluid style alterations. This tained from: n.nih.gov/dailymed/drugInfo.cf 11c68-4ade-b5f1-c488a3a335c ride extended-release tablets at agonist indicated for the ctive bladder with symptoms of inence, urgency, and ormation was obtained from:			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495394	B. WING			l	22/2048
NAME OF D	ROVIDER OR SUPPLIER	100001			STREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	22/2018
NAIVIE OF PI	ROVIDER OR SUPPLIER						
THE LAUF	RELS OF BON AIR				9101 BON AIR CROSSINGS DRIVE		
					BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	m?setid=033a9242-b 30 6. Spironolactone tab treatment of NYHA Cl reduced ejection fract manage edema, and hospitalization for hea was obtained from: https://dailymed.nlm.r	hih.gov/dailymed/drugInfo.cf bf2-49d5-8403-d07e991071 lets are indicated for lass III-IV heart failure and tion to increase survival,	F	684			
	on six occasions during the physician for Resident 6/21/18, documented for decreased Cardian HTN (hypertension), virregular heartbeat), a failure). Interventions changes. Administer of the June 20 documented, "daily wound (congestive heart failure). Review of the June 20 documented, "daily wound (congestive heart failure) administration recording the morning for chrosophic to evidence document weight on 6/12, 6/13,	nt's care plan initiated on , "Focus. CARDIAC: At risk to Output R/T (related to): A-Fib (atrial fibrillation an and CHF (congestive heart to Obtain weight and track medications as ordered." O18 physician's orders reight in the morning for chfure). Start Date: 6/12/18." O18 TAR (treatment to documented, "daily weight to documented, "daily weight tation of the resident's 6/14, 6/15, 6/19 or 6/20/18.					
		and vital signs summary ce documentation of the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED
		495394	B. WING		C 06/22/2018
A. BUILDING B. WING NAME OF PROVIDER OR SUPPLIER THE LAURELS OF BON AIR STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO				1 00/22/2010	
PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE COMPLETION
F 684	resident's weight for above. Review of the nurse documented above documentation regard those days. An interview was coa.m. with RN (regist manager. When as record for the daily "Maybe they're in the weight book and turt there was no documented and followed the photon they had not. On 6/22/18 at 12:10 staff member) #1, the director of nursifindings.	r the dates documented r's notes for the dates did not evidence arding the resident's weight for conducted on 6/21/18 at 11:57 tered nurse) #1, the unit ked to review the resident's weights, RN #1 stated, he weight book." RN #1 got the med to the resident's name, hentation of weights for the above. When asked if staff hysician's order, RN #1 stated of p.m. ASM (administrative he administrator and ASM #2, high were made aware of the	F 68	4	
	#309's wound vac (in place and function Resident #309 was 6/19/18, with diagnont limited to: Right subsequent right hip hospitalization for a disease, high blood	vacuum assisted closure) was ning per physician's orders. admitted to the facility on oses that included but were hip replacement with o wound infection requiring ntibiotic therapy, heart			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		495394	B. WING			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	I	00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 684	vein in the upper an medications) (1), an assisted closure wh piece cut to fit the w which increases blo helps with healing.) The Nursing Comprompleted on 6/19/#309 was alert, orie time. It also docume clear speech and a assessment of Resiliving (ADL) docume require the assistant ransfers, bed mobil A physician's order documented "Mainthip @ 125 mmhg (n shift for wound." The discontinuation date. A review of the base documented in part, surgical wound and (signs and symptom physician as indicated. On 6/20/18 at 11:40 observed up in his was observed runninoted that the wound wall socket.	goes into the body through a m in order to infuse long term and a wound VAC (vacuum ich is a vacuum pump, a foam round, and a vacuum tube od flow in the wound and (2) ehensive Evaluation 18 documented Resident inted to person, place and ented that Resident #309 had calm behavior. An ident #309's activities of daily ented that the resident would ity, toileting and ambulation. with a start date of 6/20/18 and wound VAC setting to right inillimeters of mercury) every its order does not have a experience of the property of the property of the property is ordered: wound VACobserve for S/S ins) of infection and report to	F 6	84		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495394	B. WING _			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	DE	00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIAT	
F 684	stated, "It [wound VA during the night." W wound VAC, LPN #2 the wound VAC to of turn it on but it did not the wound VAC was socket, so she plugg wound VAC battery. heard any alarms an reported any alarms. was off was unknown An interview was cor a.m. with LPN #9, wo informed of the abov regarding the wound unknown period the she did not know tha always be plugged in charge. When asked about the wound VAC not won, LPN #9 stated "it healing process". ASM (administrative administrator, ASM #ASM #4, the regional ASM #5, the regional made aware of the alarcology p.m. An interview was cor approximately 1:15 p. nurse) #1. She proving the wound vaccor approximately 1:15 p. nurse) #1. She proving the wound vaccor approximately 1:15 p. nurse) #1. She proving the wound vaccor approximately 1:15 p. nurse) #1. She proving the wound vaccor approximately 1:15 p. nurse) #1. She proving the wound vaccor approximately 1:15 p. nurse) #1. She proving the wound vaccor approximately 1:15 p. nurse) #1. She proving the wound vaccor approximately 1:15 p. nurse) #1. She proving the wound vaccor approximately 1:15 p. nurse)	ves on. Resident #309 C] turned off sometime hen was asked about the stated she had just found f. LPN #2 stated she tried to of work. She then saw that no longer plugged into wall ed it in to "charge up" the LPN #2 stated she had not d the night shift had not How long the wound VAC n. Inducted on 6/22/18 at 8:55 ound care nurse. When e observation and interview	F	584		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G	· /	ATE SURVEY OMPLETED
		495394	B. WING _			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	the system, system and tubing clogged.' should have soundeneither staff nor the alarm going off. She received education received education received education received education reservicing of the would she could provide a she would check for one prior to exit. An interview was consupproximately 3 p.m. They both confirmed training via an in-serservicing of a wound would be serviced in the servicing of a wound following website: https://medlineplus.gov/10/15 information following website: https://medlineplus.gov/10/15 with a read diagnoses that included in the serviced in the system of the system o	Alarm conditions are: leak in clogged, battery discharged She stated that the alarms d. RN #1 confirmed that resident complained of the confirmed that the staff had regarding the care and nd VAC. RN #1 was asked if sign in sheet. RN #1 stated one. She did not provide and conducted on 6/22/18 at with LPN #2 and LPN #3. It that they had received vice on the care and	F 6	84		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495394	B. WING _			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	ODE	09/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BI THE APPROPRIA	DATE
F 684	disorder (4), anxiety Resident # 102's modata set), a quarterly (assessment referen Resident # 102 as so interview for mental 1-15, 14 - being cogn decisions. Resident independent and red staff member for action of the physician's order 11/30/2017 to 06/30/ (cubic centimeters)/c (cubi	flux disease (3), depressive (5) and anemia (6). st recent MDS (minimum assessment with an ARD ce date) of 06/01/18, coded coring a 14 on the brief status (BIMS) of a score of 0 itively intact for making daily # 102 was coded as being uiring the assistance of one vities of daily living. rs for Resident # 102 dated 2018 documented, "1800cc lay. Fluid restriction. 00 ml (millililiters) on Day shift, ing) shift, 120 ml on Night	F6	584		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495394	B. WING				22/2018
	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 101 BON AIR CROSSINGS DRIVE 3ON AIR, VA 23235	1 007	22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	to tell how much she know if they exceede documented." LPN # documented in the nu can't tell how they har nurse's progress note 06/01/18 through 06/fluid intake for the day documented. When a to document a reside stated, "If they have them into congestive them into congestive their electrolytes." On 06/22/18 at appro (administrative staff in ASM # 2, director of in the above findings. No further information. References: (1) A long-term disease of the joints and surrous affect other organs. To obtained from the we https://medlineplus.go. (2) A chronic disease regulate the amount of information was obtain https://www.nlm.nih.go.001214.htm.	bout the lack of # 2 stated, "There is no way was given. We would not d the amount if it's not 2 stated, "It could be urse's notes, but if it isn't, d. LPN # 2 reviewed the es for Resident # 102 dated 18/18. LPN # 2 stated the y shift on 06/18/18 was not asked why it was important nt's fluid intake LPN # 2 oo much fluid it could put heart failure or throw off ximately 12:00 p.m., ASM nember) # 1, administrator, nursing were made aware of a was provided prior to exit. se. It leads to inflammation bunding tissues. It can also This information was bsite: by/ency/article/000431.htm. in which the body cannot of sugar in the blood. This ned from the website: by/medlineplus/ency/article/ s to leak back, or reflux, into ritate it. This information	F	584			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		495394	B. WING				C 22/2018
	ROVIDER OR SUPPLIER	,		9	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	(4) Depression may be blue, unhappy, miser Most of us feel this we short periods. Clinical disorder in which fee or frustration interfers or more. This inform website: https://medlineplus.g. (5) Fear. This inform website: https://www.nlm.nih.g. #summary. (6) Low iron. This inform website: https://www.nlm.nih.g. #summary. (7) Low iron. This inform website: https://www.nlm.nih.g. #summary. (8) Low iron. This inform website: https://www.nlm.nih.g. #summary. (9) Low iron. This inform website: https://www.nlm.nih.g. #summary. (10) Low iron. This inform website: https://www.nlm.nih.g. #summary. (11) Low iron. This inform website: https://www.nlm.nih.g. #summary. (12) Low iron. This inform website: https://www.nlm.nih.g. #summary. (13) Low iron. This inform website: https://www.nlm.nih.g. #summary. (14) Low iron. This inform website: https://www.nlm.nih.g. #summary.	gov/medlineplus/gerd.html. De described as feeling sad, rable, or down in the dumps. The series of sadness and series of sadness, loss, anger, the with everyday life for weeks ation was obtained from the series ov/ency/article/003213.htm. Described as feeling sad, and sadness and series of sadness, loss, anger, the with everyday life for weeks ation was obtained from the series ov/ency/article/003213.htm. Described as feeling sad, and sadness and series of sadness and sadness	F	684			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	` '	ATE SURVEY OMPLETED
		495394	B. WING			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	'	00,22,2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	toileting, personal h Review of Resident summary) dated 6/1 following order: "Da record- report gain of 24 hours or < (less if week one time a da was initiated on 4/13 Review of Resident (medication Administ check marks indicated obtained for the follo 6/5/18, 6/6/18, 6/7/16/14/18, 6/17/18, 6/14/18, 6/17/18, 6/10/18, 6/12/18, 6/10/18, 6/10/18, 6/12/18, 6/10/18, 6/12/18, 6/10/18, 6/12/18, 6/10/18,	ygiene, and bathing. #6's POS (physician order /18, documented the fily Weights- obtain and of > (greater) than 3 pounds in than) 5 lbs (pounds) in one y for heart failure." This order 3/18. #6's June 2018 MAR stration Record) revealed ing that a weight was owing days: 6/2/18, 6/4/18, 8, 6/9/18, 6/10/18, 6/12/18, 18/18, 6/19/18 and 6/21/18. Fordings could not be found in the foliation of the diameter of the clinical record ent #6 was at dialysis on the should have been obtained and order to check weight R also revealed a hole or 3/18. There was no note gift was not obtained. 8 MAR documented the strength of the should have been with the size in the should have been obtained and sorder to check weight.	F 6	34		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G	, ,	ATE SURVEY DMPLETED
		495394	B. WING			C
	ROVIDER OR SUPPLIER	10000		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		06/22/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	3/19/18 did not addr Resident #6's renal of documented the folk daily weights as well On 6/21/18 at 12:00 conducted with Resi that the facility staff percent of the time. On 6/21/18 at 12:31 conducted with LPN Resident #6's nurse the following order in dialysis on Monday, stated that weights is dialysis. When aske the resident leave for it meant for that day dialysis. LPN #2 staff the dialysis forms in obtained by the day Resident #6 leaves of dialysis. LPN #2 staff documenting the we using a weight from #2 was shown the w (dialysis day) was from #2 was shown the w (dialysis day) was from #2 was shown the w (dialysis order and LPN #2 stated, it was determine why some the dialysis book, the PCC and the weight weight may have be LPN #2 confirmed si	#6's cardiac care plan dated ess obtaining daily weights. care plan dated 3/19/18 owing intervention: "Obtain as prior to dialysis sessions." p.m., an interview was dent #6. Resident #6 stated checked his weight about 50 p.m., an interview was (licensed practical nurse) #2, that shift. When asked what neant: "Weight prior to Wednesday, Friday," LPN #2 should be obtained prior to diff that meant right before redialysis, LPN #2 stated yes, before the resident leaves for ed the 11-7 shift completed the book but weights were shift. LPN #2 stated that early in the morning for ted it appeared nursing was ight in the dialysis books the day before. When LPN eight recorded for 6/18/18, om 6/7/18; LPN #2 stated it his were also not being sked if this was following the dialysis were missing from the evital signs section under logbook. LPN #2 stated the en done but not charted. The had filled out the dialysis on 6/20/18. When asked	F 6	34		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	, ,	TE SURVEY MPLETED
		495394	B. WING			C 6/22/2018
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	, u	0/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RESCRIPTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	p.m., LPN #6 stated should be clarified by weight had to be rig most recent weight I #2 could not recall weight leaves and 6/20/18. LPN #2 stated that she was new at the On 6/22/18 at 8:20 a conducted with CNA #1. When asked why weighing residents, and one nurse will weighing residents, and one nurse will record that she did not word that she did not word that she did not word that she did not was provided. Whe sign off that a treatmy when it in fact was root okay. When ask documenting that we when they were not sure why because sup for the weight to stated that she hear weights. When ask if a resident refuses the MD (medical donotified and a nursir documented. When	eight from 6/19/18 at 3:46 she guessed the order ecause she wasn't sure if the nt before dialysis or just the nas to be documented. LPN //ny she documented ote" on the June MAR for ated she has only worked with //ny days. LPN #2 stated that facility. a.m., an interview was (certified nursing assistant) (to was responsible for CNA #1 stated that two aides //eight a resident together and //the weight. CNA #1 stated //x with Resident #6. a.m., further interview was #2. When asked what the //e MAR under a medication #2 stated that checks meant //ministered or a treatment //n asked if it was ever okay to // nent/medication was given // ot, LPN #2 stated that it was // ded why nurses were // eights were being completed // LPN #2 stated she wasn't // the thought a window popped // de entered in PCC. LPN #2 // dt hat Resident #6 refused // ed about the process followed // weights, LPN #2 stated that // ctor) and family has to be	F 6	34		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		PLETED
		495394	B. WING			C 22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00/	22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	on the care plan. LP on his care plan that On 6/22/18 at 9:20 at telephone was condumented on 6/9/#6. When asked the weights, LPN #1 statemonitor for fluid over check marks meant of stated checks marks medication/treatmented asked where daily we LPN #1 stated that didocumented in the claign tab either in PCC asked if it was ever of weight was complete LPN #1 stated that it that something was completed for Reside if a weight was not recompleted for Re	ed that it should be updated N #2 stated that it was not he refused weights. m., an interview by ucted with LPN #1, a nurse of MAR that a daily weight 18 and 6/10/18 for Resident purpose of monitoring daily ed that the purpose was to load. When asked what on the MARS/TARS, LPN #1 meant that a sewas administered. When eights were documented, aily weights were inical record; under the vital C or in a nursing note. When kay to document that a d when it was not obtained, was never okay to document and when it was not. When mented a daily weight was ent #6 on 6/9/18 and 6/10/18 ecorded in the clinical record, CNAs get weights for me. I then hung up the phone. Dom., ASM (administrative eadministrator, ASM #2, the esing), and ASM #4, the Operations, were made oncerns. No further ented prior to exit	F 68			
F 689 SS=D	Free of Accident Haz CFR(s): 483.25(d)(1) §483.25(d) Accidents	. ,	F 68	39		8/3/18

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495394	B. WING		C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 689	as free of accident has §483.25(d)(2)Each resupervision and assist accidents. This REQUIREMENT by: Based on observation document review and was determined that implement assitive document assi	esident environment remains azards as is possible; and esident receives adequate stance devices to prevent T is not met as evidenced on, staff interview, facility declinical record review, it facility staff failed to evices to prevent accidents of 32 residents in the survey 0. If to implement interventions a falls per plan of care. So of Resident #50 during the resident in bed without a fall per the comprehensive care	F 68	Resident #50s fall mat is in place. All Residents with fall mats have the potential to be affected. The DON/designee to educate nursing staff on following the comprehensive of plan regarding fall mats/fall intervention DON/designee during morning clinical meeting to conduct quality monitoring week x1 weeks, weekly x4 weeks and then monthly, PRN and indicated. Findings to be communicated to the Committee monthly and as indicated. Quality monitoring schedules modified based on findings.	care ons. 5x

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		OATE SURVEY OMPLETED
		495394	B. WING			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1	00,22,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	that she had a fall or documented: "Found (right) side at 4:05 p. changes noted. Puls 24 BP (blood pressu extend R (right) leg ii in hip area. Physicia to send guest out at daughter), notified an hospital). Transporte hospital) via (Name of transport] Service). " A fall assessment was (three days) prior to resident #50 as being Further review of the Resident #50 arrived 3/13/18 with a diagnor Review of Resident #50 arrive	ers for transfers. #50's clinical record revealed a 3/9/18. The following was a on floor next to bed on R m. No neuro (neurological) se is 124 RR (respirations) is re) is 134/92. Unable to n bed, c/o (complained) pain in notified and order received 4:10 p.m. Daughter (Name of requests (Name of red at this time to (Name of red at this time to (Name of red at this time to falls. It is completed on 3/6/18 the fall documenting right a low risk for falls. It is clinical record revealed that a back to the facility on resis of a right hip fracture. #50's fall care plan revealed that record revealed attion was initiated on 3/14/18 record plan: "Mat to floor responsible to the facility on resis of a right hip fracture. #50's admission record revealed that record plan: "Mat to floor responsible to the facility on responsible to th	F 6	89		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	` '	DATE SURVEY COMPLETED
		495394	B. WING			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	ı	06/22/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	bed with her bed up There was no fall m 6/20/18 at 2:55 p.m. bed with her bed up There was no fall m 6/21/18 at 5:00 p.m. bed with her bed up There was no fall m On 5/21/18 at 5:09 p. conducted with CNA2, Resident #50's C know what intervent their residents to protect their residents which as risk, CNA #2 stated try to get out of bed When asked if Resident behasn't had a fall marasked how long CN facility, CNA #2 stated try to get out of bed When asked if Resident had a fall marasked how long CN facility, CNA #2 stated try to get out of bed When asked if Resident had a fall marasked how long CN facility, CNA #2 stated try to get out of bed When asked if Resident had a fall marasked how long CN facility, CNA #2 stated try to get out of bed When asked if Resident had a fall marasked how long CN facility, CNA #2 stated try to get out of bed When asked if Resident had a fall marasked how long CN facility, CNA #2 stated try to get out of bed When asked if Resident had a fall marasked how long CN facility, CNA #2 stated try to get out of bed When asked if Resident had a fall marasked how long CN facility, CNA #2 stated try to get out of bed When asked if Resident had a fall marasked how long CN facility, CNA #2 stated try to get out of bed When asked if Resident had a fall marasked how long CN facility, CNA #2 stated try to get out of bed When asked if Resident had a fall marasked how long CN facility, CNA #2 stated try to get out of bed When asked if Resident had a fall marasked how long CN facility had a fall marasked how l	against the right side of wall. at in place to the left side. A Resident #50 was lying in against the right side of wall. at in place to the left side. A Resident #50 was lying in against the right side of wall. at in place to the left side. A Resident #50 was lying in against the right side of wall. at in place to the left side. A Certified nursing assistant) NA. When asked how CNAs cions need to be in place for event falls, CNA #2 stated that erbal report from the nurses. that they could look at their serve as a guide for the aides sed if Resident #50 was a fall that Resident #50 was a fall that Resident #50 does not or her chair unassisted. dent #50 needed a fall mat d, CNA #2 stated, "No. She t since I've been here." When A #2 had been working at the	F 6	39		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION 3	· /	OMPLETED
		495394	B. WING			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	communicated to Ci fall prevention intervention intervention intervention intervention intervention also had a care care the comprehensive purpose was to ider and serve as a guid stated the care plan was o was important for the Conducted with LPN Resident #50's fall r LPN #3 stated Reside to updated. On 6/22/18 at 11:19 conducted with ASN member) #2, the DO ASM #2 stated she intervention was an care plan because if the baseline care plan because if the baseline care plan was ever updated plans were updated condition, on admission on 6/22/18 at 12:02 administrator, ASM Nursing), and ASM Operations, were miconcerns. No furthe prior to exit.	nk so. When asked how it is NAs residents' needs such as ventions, LPN #3 stated imunicate with them and give resident care and the aides d. When asked the purpose of care plan, LPN #3 stated the atify limitations, needs, goals, e for resident care. LPN#3 should be followed unless at of date. LPN #3 stated it e care plan to be accurate. a.m., further interview was l#3. LPN #3 confirmed that was on the care plan. It dent #50 does not attempt to the care plan should probably a.m., an interview was laministrative staff DN (Director of Nursing). It dought the fall mat the error on the comprehensive that was not an intervention of an. When asked if the care with any changes in sion and quarterly.	F 68	9		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495394	B. WING		C 06/22/2018	
	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00/22/2010	
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F 689 F 694 SS=D	Program," did not ac Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenter Parenteral fluids mus with professional star accordance with phycomprehensive personal the resident's goals at This REQUIREMENT by: Based on observation interview, facility doc record review, it was staff failed to provide the care of an intraveresidents in the surveresidents in the surveresidents in the surveresident #311. The findings include: Resident #311 was a 6/8/18 with diagnose limited to: infection or irregular heart beat, or pressure and urinary. The most recent MD admission assessment reference date) of 6/1 having scored a 12 of the parent resident and reference date of 6/1 having scored a 12 of the parent reference date	al Fluids. It be administered consistent indards of practice and in sician orders, the con-centered care plan, and and preferences. This not met as evidenced on, resident interview, staff ument review and clinical determined that the facility treatment and services for enous line for one of 32 by sample, Resident #311. If to change the intravenous instead of the seven days dard after admission for the hip, heart failure, diabetes, high blood tract infection. Show the facility on the seven days days days after admission for the hip, heart failure, diabetes, high blood tract infection. Show the facility on the hip heart failure, diabetes, high blood tract infection. Show the facility on the hip heart failure, diabetes, high blood tract infection.	F 689		on g s.	
	admission assessme reference date) of 6/ having scored a 12 o interview for mental s	nt with an ARD (assessment 15/18 coded the resident as				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 694	of Resident #311. The alert and sitting up or resident's wife was all had a PICC (a periph catheter (1)) line in hi was covered with a tr could be seen on the dressing had been chadmitted to the facility wife both said it had resident initiated on 6/8/18 doe PICC Line dressing (a Review of the June 2 documented, "PICC Line dressing (a Review of the June 2 documented, "PICC Line dressing (a Review of the June 2 administration record schedule for the PICC the upper left corner (a labeled Unscheduled dressing change" was An interview was con a.m. with LPN (licens When asked about the a resident had a PICC clean the IV port with syringe, and check for when the PICC line d #2 stated, "Our protor First I'm going to chereviewed the resident	nade on 6/19/18 at 6:30 p.m. e resident was awake and in the side of the bed. The so in the room. The resident erally inserted central is right upper arm, which ansparent dressing. No date dressing. When asked if the eranged since he was if the was if t	F	694				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
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F 694	me how often to char reviewed the June 20 (treatment administra "There's nothing ther wrote change PICC I the orders to see how the doctors want it do every seven days." \ PICC line dressing hadmission, LPN #2 s since there was no so document it. An interview was comp.m. with LPN (licens nurse who cared for about the process stand a PICC line, LPN them you make sure the dressing gets changed, LPN #8 stand when asked if she had PICC line dressing sistated, "No." On 6/22/18 at 12:10 staff member) #1, the director of nursing findings. Review of the facility venous Catheter (CN documented, "To Be nurses according to so The nurse shall be co of infusion therapy were shall be cored to the staff of the shall be cored to	sing change' so it's not telling nge it." LPN #2 then	F	594			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
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F 694	infusion therapy with practice. Considerati site is a potential ent cause a catheter-rela Sterile dressing char dressings is performed post-insertion or upon weekly. 1.3 If the interest of the post-insertion or upon weekly. 1.3 If the interest of the post-insertion or upon weekly. 1.3 If the interest of the post-insertion or upon weekly. 1.3 If the interest of the post-insertion or upon weekly. 1.3 If the interest of the post-insertion or upon weekly. 1.3 If the interest of the post-insertion or upon weekly. 1.3 If the interest of the post-insertion or upon weekly. 1.3 If the interest of the post-inserted into a portion of the post-inserted into a portion of the post-inserted central catherobtained from:	ining competence with in her or his scope of ons: 2. The catheter insertion ry site for bacteria that may ated infection. Guidance: 1. age using transparent ed: 1.1 24 hours in admission. 1.2 At least agrity of the dressing has wet, loose or soiled). " In was provided prior to exit. How to care for the catheter change should be done 24 and every 7 days or when or loose. This information add to draw blood and give intravenous fluids, drugs, or a thin, flexible tube is inserted are arm and guided the vein above the right side of superior vena cava. A needle is outside the body to draw A PICC may stay in place for the catheter for the catheter change should be done? A PICC may stay in place for the catheter arm and guided the pody to draw the place for the catheter change should be determined by the place for the catheter change should be determined by the place for the p	F6	94		
F 695 SS=D	ancer-terms/def/picc Respiratory/Tracheo	nov/publications/dictionaries/c	Fé	95		8/3/18

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COM	(X5) PLETION DATE
F 695	§ 483.25(i) Respirator tracheostomy care and tracheostomy care and The facility must ensineeds respiratory care and tracheal succare, consistent with practice, the compreheated and 483.65 of this sufficient that provide respiratory care record review, and fawas determined that provide respiratory care respiratory care respiratory care plan, the resident that provide respiratory care plan, the resident that provide respiratory care record review, and fawas determined that provide respiratory care respiratory care residents in the surface for the admin Resident #74. 2. The facility staff fawas respiratory the manner. 3. The facility staff fawas according to the place for the admin Resident #74. Resident #74 was according the resident #74. Resident #74 was according the resident #74.	any care, including and tracheal suctioning. The tracheal suctioning are that a resident who are, including tracheostomy ectioning, is provided such professional standards of the sive person-centered ants' goals and preferences, abpart. This not met as evidenced are in the facility staff failed to are and services for three of the sident are included are in the facility staff failed to are and services for three of the sident are in the facility staff failed to are and services for three of the sident are instration of oxygen to a sanitary and the sident are grown as	F 69	Resident #74 no longer resides in facility. Resident#94 no longer resident the facility. Resident #64 oxygen is administered as per Physician order All residents with orders for oxygen/nebulizer treatments have to potential to be affected. The Don/designee to educate Nurses staff on following Physician orders oxygen and storing respiratory there equipment in a sanitary manner. Don/designee to conduct quality monitoring 5x a week x1 week, week weeks and then monthly, PRN and indicated. Findings to be communicated to the committee monthly and as indicate Quality monitoring schedules modificated on findings.	des in being rs. he ing for appy ekly x4 e QA d.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 695	heel pressure ulcer, pressure, chronic ki attack. The most research was an admiss (Assessment Referencesident was coded to make daily life decomplete of the daily life of t	atrial fibrillation, diabetes, left glaucoma, high blood dney disease, and a heart ecent MDS (Minimum Data ion assessment with an ARD ence Date) of 5/31/18. The as cognitively intact in ability ecisions. of Resident #74 on 6/20/18 at /18 at 2:15 p.m., revealed the he oxygen concentrator was minute; and on 6/21/18 at gen concentrator flowrate was nute. cal record failed to reveal any he administration of oxygen. e. a.m., in an interview with RN exp., she stated that there order for oxygen. RN #4 just checking up on the sersident because she has no order for it in the eMAR Medication Administration end why there should there be the province of the resident and you oxygen or not enough.	F6	95		
		ity policy, "Nasal Cannula" did ction that the use of oxygen o's order.				

		(X3) DATE COMP	SURVEY LETED				
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	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
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F 695	ordered by physician On 6/22/18 at 12:30 staff member) #1 (th (the Director of Nurs findings. No further informatio the survey. {1} According to Fun Edition, Lippincott W 851, "Because oxyge	y policy, "Oxygen mented, "2. Turn adjust liter flow (to that)" p.m., ASM (administrative e Administrator) and ASM #2 ang) were made aware of the mass provided by the end of damentals of Nursing, Fifth illiams & Wilkins, 2007, page en is a drug, its use requires with all drugs, the potential	F	695			
	#94's respiratory the manner. Resident #94 was ac 5/1/18 with the diagr sepsis, diabetes, MF Staphylococcus Aure aftercare, cellulitis of tenosynovitis of left lankle and foot, gout, atrial fibrillation, high venous insufficiency of ankle and foot, an The most recent MD an admission assess (Assessment Refere	ailed to maintain Resident rapy equipment in a sanitary dimitted to the facility on oses of but not limited to the test of the second of the s					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 695	3ml (per 3 milliliters), as needed for SOB (swheezing, via nebuliz A review of the MAR Record) revealed tha administered the neb at 12:39 p.m., and 6/- Observations were m 6/20/18 at 11:14 a.m. the resident's nebuliz on the bedside nights was dated 6/13/18 ar On 6/21/18 at 11:07 a #4 (Registered Nurse facemask should be so On 6/22/18 at 9:32 a. #1, she stated that the be in a plastic bag for A review of the facility Ventilator Dependent Disassemble nebulizer policy." There was no store the nebulizer m control. On 6/22/18 at 12:30 p staff member) #1 (the	al record revealed a ed 5/1/18 for 10.5-2.5 3mg (milligrams) / inhale orally every 4 hours shortness of breath) or ter." (Medication Administration to the resident was ulizer treatment on 6/13/18 15/18 at 6:25 p.m. adde of Resident #94 on , and 6/20/18 at 3:02 p.m., er machine was observed stand. The nebulizer mask and was not in a bag. a.m., in an interview with RN e), she stated the nebulizer stored in a plastic bag. m., in an interview with RN e nebulizer facemask should infection control reasons.	F	695			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(X3) DATE COMP	SURVEY LETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page 193 No further information was provided by the end of		F 6	95			
	the survey. 3. The facility staff factorial f	ailed to administer Resident # ag to the physician's orders. dmitted to the facility on mission of 03/13/18 with led but were not limited to (1) of the larynx (2), flux disease (3), chronic ry disease (4), tracheostomy atic hyperplasia (6). trecent MDS (minimum data assment with an ARD ce date) of 05/18/18, coded oring a 14 on the brief status (BIMS) of a score of 0 itively intact for making daily # 64 was coded as requiring of one staff member for g. Under section "O. Special es and Programs" Resident C. Oxygen therapy and E.					
	receiving oxygen from a tracheostomy tube. mete on the O2 (oxygen three and a half liter) An observation on 06 revealed Resident # watching television, r	6/20/18 at 12:45 p.m.,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 695	Observation of the fl concentrator revealed minute. An observation on 0 revealed a nurse en per his request and observation on at 12 # 64, sitting up in be receiving oxygen fro a tracheostomy tube mete on the O2 (oxy three and a half liter. An observation on 0 revealed Resident # watching television, oxygen concentrator. Observation of the fl concentrator revealed minute. The physician's orde 03/03/2018 through "Oxygen 5 (five) I/mi (tracheostomy) ever 03/13/2018. Start D. The EMAR (electror record) dated June 2 documented, Oxygeminute) via trach (tracheostomy) via trach (tracheostomy) at 13/2018." documented Reside	dow mete on the O2 (oxygen) and three and a half liter per 6/20/18 at 12:53 p.m., tered resident # 64's room closed the door. An 2:54 p.m., revealed Resident and, watching television, and an oxygen concentrator via a c. Observation of the flow argen) concentrator revealed per minute. 6/21/18 at 10:55 a.m., 64, sitting up in bed, receiving oxygen from an an an article at tracheostomy tube. How mete on the O2 (oxygen) and three and a half liter per ers for Resident # 64 dated 06/30/18 documented, in (liters per minute) via trach by shift. Order Date:	F 6	95		
		care plan for Resident # 64 umented, "Need. Potential				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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F 695	difficulty Breathing F (shortness of breath abnormal pulse, oxin (HTN [hypertension] pulmonary disease], squamous cell canco 03/14/2018." Under documented, "Admin treatment per physic effectiveness, side of medications and tabnormal findings to Oximetry, Suction, the levate HOB (head of the ball of the ball." When asked how flow rate is checked every four hours and resident's room." When the ball of the ball. "If the ball of the ball." If the ball of the ball. The line middle of the ball." If the ball of the ball. The ball of the ball of the ball of the ball of the ball. The ball of the ball. The ball of the ball. The ball of the ball. The ball of the ball	R/T (related to): SOB), abnormal respiration, metry,R/T cardiac condition, , COPD [chronic obstructive Tracheostomy, Cancer, er of lung). Date initiated: "Interventions" it nister medication & (and) cian's order. Monitor for effects and adverse reactions reatments and report o physician. Oxygen, Pulse rach (tracheostomy) care,	F 6	95		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 695	LPN # 5 then turned to flow meter to increase stated, "It won't go to 5 approached this surread the flow meter of LPN # 5 stated, "You ball, his (Resident # 6 a half liters. I also choncentrator." When follow the physician's of oxygen, LPN # 5 stated, "Pour getting enough ox cause loss of life or life. The "(Name of Oxyget Manual" documented properly read the flow flowrate line in the flow knob until the ball rise the ball on the L/min of prescribed." The facility's policy "Odocumented, "Proced on and adjust the liter physician). Listen for liter flow ball on the gother middle of the numprescribed by the phybe checked by being meter." On 06/22/18 at appro (administrative staff in ASM # 2, director of in the above findings.	the knob at the top of the ethe oxygen flow rate and five." At 11:15 a.m., LPN # reyor regarding on how to in the oxygen concentrator. It will be at eye level with the adds out the oxygen was at four and anged out the oxygen asked why it is important to order for the administration rated, "If it's not given he is aygen as he needs and could mb." The Concentrator of User's are concentrator. User's are concentrator of the prescribed of the concentrator. It is the concentrator of the prescribed of the concentrator. It is the concentrator of the prescribed of the concentrator. Now, center	F6	995		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495394	B. WING		06/22/2018	
	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF BON AIR (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 695 Continued From page 197 References: (1) The term "malignancy" refers to the presence of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. Malignant cells tend to have fast, uncontrolled growth and DO NOT die normally due to changes in their genetic makeup. Malignant cells that are resistant to treatment may return after all detectable traces of them have been removed or destroyed. This information was obtained from the website: https://medlineplus.gov/ency/article/002253.htm. (2) The larynx, or voice box, is located in the neck and performs several important functions in the body. The larynx is involved in swallowing,			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 695	References: (1) The term "malign of cancerous cells to other sites in the invade nearby (local Malignant cells tend growth and DO NO in their genetic mak resistant to treatmed detectable traces of destroyed. This in the website: https://medlineplus. (2) The larynx, or voland performs sever body. The larynx is breathing, and voice produced when the vocal cords causes sound waves in the The pitch of sound in of tension on the voland of tension on the voland was obtained from the esophagus and was obtained from the esophagus and was obtained from the the the pitch of sound in the esophagus and was obtained from the esophagus and was obtained from the the esophagus and was obtained from the the solution of the the solution of the the solution of the solution of the esophagus and was obtained from the these.//www.nlm.nih	nancy" refers to the presence hat have the ability to spread body (metastasize) or to lly) and destroy tissues. It to have fast, uncontrolled I die normally due to changes eup. Malignant cells that are not may return after all them have been removed or information was obtained from gov/ency/article/002253.htm. Dice box, is located in the neck all important functions in the involved in swallowing, are production. Sound is air which passes through the them to vibrate and create pharynx, nose and mouth. Is determined by the amount cal folds. This information he website: gov/ency/imagepages/19708. Its to leak back, or reflux, into irritate it. This information he website: gov/medlineplus/gerd.html. I kes it difficult to breath that its of breath). This information	F 69	5		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG	(X3) DATE COMP	SURVEY
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F 695	provide an airway and the lungs. This tube is or trach tube This ir from the website: https://medlineplus.gd (6) An enlarged prost obtained from the wel https://www.nlm.nih.g statebph.html. Pain Management CFR(s): 483.25(k) §483.25(k) Pain Mana The facility must ensure provided to residents consistent with profest the comprehensive peand the residents' goard the residents' goard the resident in facility document revier review, it was determ failed to implement a management program	ced through this opening to d to remove secretions from a called a tracheostomy tube of the second o		Non-Pharmacological pain intervent are being used for Resident #37. Re #67s location of pain and effectivene pain medication administered is bein documented. All residents have the potential to be affected. The DON/designee to educate nursing the potential to be affected.	sident ss of	8/3/18
	prn (as needed) pain 37. 2. The facility staff fa	ventions prior to the use of medication for Resident #		Staff on using non-pharmacological interventions for pain management a as educating on documentation of th location of pain and the effectiveness pain medication administered. DON/designee during morning clinical	s well e of	
	location pain and the medication administe	effectiveness of pain red to Resident #67 on		meeting to conduct quality monitoring week x1week, weekly x4 weeks and		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495394	B. WING _				C / 22/2018	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 697	Continued From page	e 199	F 6	697				
	multiple occasions du The findings include:	ıring June 2018.			monthly, PRN and indicated. Findings to be communicated to the Q committee monthly and as indicated. Quality monitoring schedules modified based on findings.	A		
		iled to attempt non- ventions prior to the use of medication for Resident #						
	Resident # 37 was admitted to the facility on 10/15/17 with a readmission of 04/03/18 with diagnoses that included but were not limited to peripheral vascular disease (1) diabetes mellitus (2), chronic kidney disease (3), depressive disorder (4), anxiety (5) and anemia (6).							
	set), a quarterly asse (assessment reference Resident # 37 as sco interview for mental s	ce date) of 04/24/18, coded ring a 10 on the brief tatus (BIMS) of a score of 0 erately impaired of cognition						
	04/01/2018 documen 7.5-325 MG (milligrar (Hydrocodone-Acetar tablet by mouth every	rs for Resident # 37 dated ted, "Norco (7) Tablet. n) minophen). Give 1 (one) of (six) hours as needed for daily amount 4 (four) tab						
	record) for Resident # documented the above Further review of the							

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	l\ /	ATE SURVEY DMPLETED
		495394	B. WING _			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	<u>'</u>	00.22.2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 697	(four). On 04/07/18 at 1533 of 9 (nine) and at 21 level of 9 (nine). On 04/08/18 at 9:10 (nine), at 1615 (4:16 (eight) and at 2232 of 8 (eight). On 04/09/18 at 2053 of 3 (three). On 04/13/18 at 1306 of 6 (six). On 04/14/18 at 11:0 (six) and at 2017 (8:0 (three)). On 04/15/18 at 5:13 (eight). On 04/16/18 at 5:28 (seven). On 04/16/18 at 5:28 (seven). On 04/21/18 at 8:55 (four) and at 1714 (8:0 (five)). On 04/22/18 at 8:12 (three) and at 1815 of 8 (eight). On 04/28/18 at 1:06 (four). On 04/30/18 at 1708 of 6 (six). The EMAR (electror record) for Resident documented the aboreview of the EMAR 7.5-325 MG was ad	ge 200 a.m., with a pain level of 4 2 (3:32 p.m.) with a pain level 41 (9:41 p.m.) with a pain a.m. with a pain level of 9 5 p.m.) with a pain level of 8 (10:32 p.m.) with a pain level 6 (1:06 p.m.) with a pain level 6 (1:06 p.m.) with a pain level 6 (1:06 p.m.) with a pain level 7 (8:57 p.m.) with a pain level 8 (1:08 p.m.) with a pain level of 3 2 a.m., with a pain level of 3 3 (8:33 p.m.) with a pain level of 7 3 (8:33 p.m.) with a pain level a.m., with a pain level of 4 5:14 p.m.) with a pain level of a.m., with a pain level of 3 (6:15 p.m.) with a pain level a.m., with a pain level of 4 9 (5:09 p.m.) with a pain level a.m., with a pain level of 4 6 (6:06 p.m.) with a pain level a.m. with a pain level of 4	F 6	97		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495394	B. WING				22/2018
	ROVIDER OR SUPPLIER		,	9	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	of 5 (five). On 05 14/18/18 at 9 (six). On 05/15/18 at10:22 (five). On 05/15/18 at 9:08 (six). On 05/19/18 at 1735 of 5 (five). On 05/20/18 at 8:23 (three) and at 1815 of 6 (six). The EMAR (electror record) for Resident documented the aboreview of the EMAR 7.5-325 MG was ad 9:25 a.m., with a paid The comprehensive dated 04/04/2018 do for pain r/t (related to amputation) and right amputation), H/O (h vascular accident) [shemiparesis, CKD (c Diabetes, neuropath (coronary artery dise (peripheral vascular Retinopathy. Date in "Interventions" it doc for comfort with physpate initiated: 04/04 Review of the nurse	2 (5:39 p.m.) with a pain level 208 a.m. with a pain level of 6 2 a.m. with a pain level of 5 a.m.) with a pain level of 6 5 (5:53 p.m. with a pain level a.m. with a pain level of 3 (6:18 p.m.) with a pain level a.m. with a pain level of 3 (6:18 p.m.) with a pain level aic medication administration # 37 dated June 2018 ave physician's order. Further revealed the Norco Tablet. ministered on 06/18/18 at n level of 4 (four). care plan for Resident # 37 acumented, "Need. Potential b): AKA (above the knee at BKA (below the knee at stroke], with right chronic kidney disease), by, HTN, hyperlipidemia, CAD asse), anemia, PVD disease) Vertigo, nitiated: 04/04/2018." Under cumented, "Assist to position sical support as necessary.	F	697			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495394	B. WING			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	'	3672212316
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 697	interventions prior to tablet. On 06/21/18 at appinterview was condupractical nurse) # 2. process for adminismedications LPN # resident's) pain leves scale with 10 being is located, and descriphysician's order arpain. Before giving non-pharmacological the resident's pain a would give the med pharmacological into documented in the reviewing the nurse # 37 dated 04/06/18 was asked if non-pwere attempted before administered. LPN adocumentation of no interventions were attempted with Resnurse's attempt to rebefore administering to resident and the statement of the	roximately 2:20 p.m., an ucted with LPN (licensed When asked to describe the tering PRN (as needed) pain 2 stated, "Ask their (the el using a 0 (zero) to 10 pain the worse, ask where the pain the worse, ask where the pain the worse what they have for the medication I would try that interventions first, recheck and if it was not effective I dication. The non-terventions would be nurse's progress notes." After is progress notes for Resident B through 06/18/18, LPN # 2 tharmacological interventions word pharmacological	F 69	,		
	On 06/22/18 at app (administrative staff	roximately 12:00 p.m., ASM member) # 1, administrator, f nursing were made aware of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED		
		495394	B. WING			C 06/22/2018	
	RELS OF BON AIR			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	<u>'</u>	00/22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 697	No further information References: (1) The vascular symblood vessels. It incompiliaries that carry Arteries can become called atheroscleros vessels and block by Weakened blood vessels in the whote in the weakened blood by Metallia in the website: https://wedlineplus.l. (4) Depression may blue, unhappy, missels whost of us feel this short periods. Clinical disorder in which feor frustration interfeor more. This information website: https://medlineplus.	on was provided prior to exit. stem is the body's network of cludes the arteries, veins and y blood to and from the heart. e thick and stiff, a problem sis. Blood clots can clog blood flow to the heart or brain. essels can burst, causing body.) This information was	F 69				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY PLETED
		495394	B. WING	P WINC			C
		495394	B. WING			06/	22/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE LAU	RELS OF BON AIR				9101 BON AIR CROSSINGS DRIVE		
				ı	BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	Continued From page https://www.nlm.nih.g #summary. (6) Low iron. This info the website: https://www.nlm.nih.g. (7) Hydrocodone is all opioid is sometimes of Acetaminophen is a li increases the effects. The combination of an hydrocodone is used severe pain. This info the website: https://www.rxlist.commages-side-effects.htm. 2. The facility staff fallocation pain and the medication administer multiple occasions during the medication administer multiple occasions during the medication #67 was additional.	e 204 nov/medlineplus/anxiety.html formation was obtained from nov/medlineplus/anemia.html in opioid pain medication. An called a narcotic. less potent pain reliever that of hydrocodone. cetaminophen and to relieve moderate to formation was obtained from in/norco-5-325-drug/patient-itm. illed to document the effectiveness of pain red to Resident #67 on		697	DEFICIENCY)		
	spasms, dorsalgia, de pressure, anxiety disconstruction most recent MDS (Mi admission/5-day asse (Assessment Referer resident was coded a ability to make daily li A review of the clinica 6/4/18 for "Oxycodon"	order, and depression. The nimum Data Set) was an essment with an ARD nce Date) of 5/14/18. The s being cognitively intact in					

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		` ′	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495394	B. WING			C 06/22/2018
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		, 33.22.20.10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 697	"moderate to severed A review of the Junresident received the times), 6/2/18 (2 tim (1 time), 6/5/18 (2 times), 6/8/18 (3 6/10/18 (2 times), 6/14/18 (2 times), 6/14/18 (2 times), 6/14/18 (2 times), 6/19/18 (2 times), 6/19/	hat pain levels constituted as e." e 2018 MAR revealed the me medication on 6/1/18 (2 mes), 6/3/18 (3 times), 6/4/18 times), 6/6/18 (2 times), 6/7/18 times), 6/6/18 (1 time), 6/13/18 (1 time), 6/15/18 (3 times), 6/15/18 (3 times), 6/15/18 (3 times), and 6/20/18 (3 times). 39 opportunities. Of these 39 medication was administered than 5 on 7 occasions. of the clinical record revealed ation was given without more of the location of the pain ortunities. e clinical record revealed that up pain scale on 2 of the 39 miled to reveal evidence of al interventions being the 39 opportunities.	F 69	7		
	Resident #67, she stries other things.	5 a.m., in an interview with stated that they (the facility)				
	(registered nurse) # assessments. RN a resident alert and o on a 0-10 scale, de crying, tense, what	3 a.m., in an interview with RN 44, regarding pain 44 stated, "vital signs, is the riented, what is their pain level meanor, are they responding, is the location of the pain, acological interventions				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		495394	B. WING _			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	I	00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 697	is. Try repositioning order states to give how do staff know w pain, RN #4 stated is anything above a 4. classification is door saw it somewhere. process staff follows been given to a resi within an hour to rea effectiveness and a stated that all this sl. On 6/22/18 at 9:29 at #1, she stated that all and 7-19 is severe. In not get an oxycodor considered mild. A correlation of the numoderate, severe where the Oxycodone for a stated, that the residence in the considered 4 or over the oxycodone for a stated, that the residence in the considered 4 or over the oxycodone for a stated, that the residence in the considered 4 or over the facility or the	the pain is from and where it it, ice, etc." When asked if an for moderate to severe pain, what constitutes moderate moderate pain is classified as When asked where this umented, RN #4 stated she When asked about the stafter pain medication has dent, RN #4 stated a follow up assess level should occur for pain level rating. RN #4 mould be documented. a.m., in an interview with RN is a mild, 4-6 is moderate, is she stated a resident should be for a level of 3 because it is facility standard for the mber scale to "mild, was requested. a.m., in an interview with the moderate would be a sked if a nurse can give a pain level of "3" then, she dent can request it but that in't give it for a level of 3 (if the lerate and moderate is	F 6	97		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495394	B. WING			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 697	the guest to rate the scale of one (1) to tel Moderate Pain, 10 = 12the nurse will do variations and rhythin pain, what relieves the increases the pain as observations. 13. The effects the pain has observations. 13. The effects the pain has observations and chronic interventions" A review of the care possible for "Potential spasms and chronic surgeries." The inter 5/18/18, for "Instruct needed and offer condistraction, back rubs position, etc." On 6/22/18 at 12:30 staff member) #1 (the Director of Nursifindings. No further in the end of the survey worderate to severe purpormation obtained)	rel11. The nurse will ask intensity of the pain with the in (10) with: 0 = No Pain, 5 = Worst Possible Pain. Socument the onset, duration, as, manner of expressing are pain, and what causes or a subjective and objective enurse will document the on the guestthe nurse will eplan for pain relief, all and non-medicinal colan revealed one dated for pain r/t (related to) back pain from multiple back eventions included one, dated in relaxation techniques as an fort measure such as: as, slow breathing, change of co.m., ASM (administrative expanding the Administrator) and ASM #2 ang) were made aware of the information was provided by a codone is used to relieve the pain.	F 6	97		
F 698 SS=D			F 6	98		8/3/18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495394	B. WING		C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 698	§483.25(I) Dialysis. The facility must ensure require dialysis recewith professional state comprehensive persure the residents' goals. This REQUIREMEN by: Based on resident if facility document review, it was determediated to provide treated are of a dialysis resingular the survey sample. The facility staff failed weights prior to dialy plan of care on several 2018. The findings include Resident #6 was add 12/6/17 with diagnost limited to end stage type two diabetes are pulmonary disease). MDS (minimum data quarterly assessment reference date) of 30 coded as being cognimate dialy decisions 15 on the BIMS (Bridexam. Review of Resident summary) dated 6/1 following orders: "W	sure that residents who give such services, consistent andards of practice, the son-centered care plan, and and preferences. IT is not met as evidenced onterview, staff interview, wiew, and clinical record on the staff atment and services for the sident, for one of 32 residents are, Resident #6.	F 698	Resident #6s weight is being obtaine and documented as per Physician or All residents have the potential to be affected. The DON/designee to educate nursir staff on obtaining and documenting residents weights as per Physician o Don/designee during Morning Clinica Meeting to conduct quality monitoring week x1 weeks, weekly x4 weeks an then monthly, PRN and indicated. Findings to be communicated to the committee monthly and as indicated. Quality monitoring schedules modified based on findings.	der. ng rder. ll g 5x d

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	COMPLETED		
		495394	B. WING		C 06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	, 33.2.20.10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPRIES OF THE APPROPROPRIES OF THE APPROPRIES	D BE COMPLETION	
F 698	> (greater) than 3 print than 3	ain and record- report gain of bunds in 24 hours or < (less of in one week one time a day his order was initiated on #6's Renal Care Plan dated of the following intervention: as as ordered as well as prior #6's June 2018 MAR stration record) revealed that ialysis on the following days: becomented that Resident #6 and 6/18/18; a check mark obtained prior to dialysis. A lud not be found in the clinical of 6/4/18 could not be found on g kept at the nursing station. Iniciation form for 6/4/18 could	F 69	8		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3	(X3) DATE SURVEY COMPLETED		
		495394	B. WING			C 06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		1 00/22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 698	Review of the dialys 6/6/18 revealed that 6/6/18 was not prior recorded from 6/5/18 was documented: "V 11:20 a.m." Review of the dialys 6/18/18 revealed that 6/18/18 was not prior recorded was from 6 following was docum 6/7/18 at 139 p.m." Further review of the resident was docum home" on the following 6/11/18, and 6/15/18 was not prior of the clinical record was coded as being because he was at 6/11/18 and 6/15/18 that the weights wer dialysis. Further review of the weight could not be weight could not be at the nursing station communication form blank for weight, ind not obtained prior to	is communication form dated the weight documented for to dialysis. The weight was at 11:20 a.m. The following Veight: 126.2 date: 6/5/18 at is communication form dated at the weight documented for or to dialysis. The weight 6/7/18 at 1:39 p.m. The mented: "Weight 128.6, date ented as being "Absent from ing dialysis days: "6/8/18, 3." 6/11/18, and 6/15/18 could clinical record. Further review revealed that Resident #6 "Absent from home" dialysis. Review of the ion form dated 6/8/18, revealed blanks indicating e not obtained prior to e. June 2018 MAR revealed a dialysis day 6/13/18. A found in the clinical record. A found on the weight log kept in. Review of dialysis dated 6/13/18 revealed a dialysis day 6/13/18 revealed a icating that the weight was	F 69	98			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			DATE SURVEY COMPLETED
		495394	B. WING			C
	ROVIDER OR SUPPLIER	100007		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	·	06/22/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 698	Nurse/Note." Reviet to evidence why his to dialysis. On 6/21/18 at 12:00 conducted with Resthat the facility staff percent of the time. On 6/21/18 at 12:31 conducted with LPN Resident #6's nurse the following order redialysis on Monday, stated that weights dialysis. When askethe resident leave for it meant for that day dialysis. LPN #2 stathe dialysis forms in obtained by the day Resident #6 leaves dialysis. LPN #2 stathe dialysis. LPN #2 stathe dialysis forms in obtained by the day Resident #6 leaves dialysis. LPN #2 stathe dialysis day) was frappeared daily weight of the weight weight may have be LPN #2 confirmed sommunication form	ge 211 ed for 6/20/18: "Hold/See w of the nursing notes failed weight was not obtained prior p.m., an interview was ident #6. Resident #6 stated checked his weight about 50 p.m., an interview was I (licensed practical nurse) #2, that shift. When asked what meant: "Weight prior to Wednesday, Friday," LPN #2 should be obtained prior to ed if that meant right before or dialysis, LPN #2 stated yes, before the resident leaves for ted the 11-7 shift completed the book but weights were shift. LPN #2 stated that early in the morning for ated it appeared nursing was eight in the dialysis books the day before. When LPN weight recorded for 6/18/18, om 6/7/18; LPN #2 stated it phts were also not being lisked if this was following the ad comprehensive care plan, as not. LPN #2 could not be weights were missing from the vital signs section under to logbook. LPN #2 stated the teen done but not charted. The head filled out the dialysis to no 6/20/18. When asked the leight from 6/19/18 at 3:46	F 69	98		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495394	B. WING _			C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	<u> </u>	00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 698	should be clarified by weight had to be rig most recent weight #2 could not recall with Hold/See nurses not 6/20/18. LPN #2 state Resident #6 for a fe she was new at the Con 6/22/18 at 8:20 a conducted with CNA#1. When asked with weighing residents, and one nurse will with the nurse will record what the following of dialysis on Monday, stated a weight shour resident leaves for a did not work with Recurrently have any of order. On 6/22/18 at 8:25 a conducted with LPN checks meant on the and treatment, LPN a medication was as was provided. Whe sign off that a treatment when it in fact was renot okay. When as documenting that we will we will be well as the conducted with LPN and treatment, LPN and was provided. Whe sign off that a treatment when it in fact was renot okay. When as documenting that we will be will	she guessed the order because she wasn't sure if the ht before dialysis or just the has to be documented. LPN why she documented bete on the June MAR for lated she has only worked with w days. LPN #2 stated that	F 6			
	up for the weight to stated that she hear	the thought a window popped be entered in PCC. LPN #2 rd that Resident #6 refused ed about the process followed				

PRINTED: 07/20/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		1' '	(X3) DATE SURVEY COMPLETED		
		495394	B. WING _	B. WING		C / 22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		12212010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 758 SS=D	the MD (medical doct notified and a nursing documented. When a followed if a resident weights, LPN #2 state on the care plan. LPI on his care plan that I on 6/22/18 at 12:02 pstaff member) #1, the DON (Director of Nur Regional Director of Caware of the above of the above of the facility policy title Coordination of Servifollowing: "The Facility form will be complete sent with the guest to Facility Dialysis Complete sent with glanging information that appointment. Oral into Most recent vital sign weighed between trea with plan of care. Oth No further information Free from Unnec Psy CFR(s): 483.45(c)(3) A psychaffects brain activities processes and behave	veights, LPN #2 stated that or) and family has to be note has to be sked about the process consistently refuses ed that it should be updated N #2 stated that it was not he refused weights. o.m., ASM (administrative administrator, ASM #2, the sing), and ASM #4, the Operations, were made oncerns. d, "Hemodialysisces" documents in part the y Dialysis Communication d by the charge nurse to be the dialysis center. 3. The munication form may contain ion: Changes in guest's since last exam. Guests we since last dialysis ake since last appointment. S. Most recent weight if atments. Guests compliance er appropriate comments." In was presented prior to exit. chotropic Meds/PRN Use (e)(1)-(5)	F 6	758		8/3/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495394	B. WING		C 06/22/2018
	ROVIDER OR SUPPLIER	1	,	STREET ADDRESS, CITY, STATE, ZIP CODE 2101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 758	system the facility of system to the clinical record; system to the clinical interventic contraindicated, in a drugs; system to the clinical record; system	nensive assessment of a must ensure that ents who have not used are not given these drugs on is necessary to treat a diagnosed and documented ents who use psychotropic al dose reductions, and ons, unless clinically n effort to discontinue these ents do not receive oursuant to a PRN order on is necessary to treat a condition that is documented and orders for psychotropic drugs s. Except as provided in attending physician or her believes that it is ern order to be extended or she should document their ent's medical record and	F 758		

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE SURVEY COMPLETED
	495394	B. WING		C 06/22/2018
			9101 BON AIR CROSSINGS DRIVE	00/22/2010
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
renewed unless the prescribing practition the appropriateness. This REQUIREMEN by: Based on staff inte and facility docume that the facility staff residents was free or Residents was free or Residents # 32 and 1. For Resident #3 ensure a proper dia [Quetiapine Fumara 2. For Resident #8 ensure a proper dia Seroquel. The findings include 1. For Resident #3 ensure a proper dia Seroquel. The sident # 32 was ensure a proper dia (1). Resident # 32 was 08/12/16 with diagn not limited to Alzhei and dysphagia (4). Resident # 32's mo set), a quarterly ass (assessment refere Resident # 32 as so interview for mental - 15, 0 (zero) - bein	attending physician or mer evaluates the resident for sof that medication. It is not met as evidenced rview, clinical record review, not review, it was determined failed to ensure two of 32 of unnecessary medications, #81. 2, the facility staff failed to gnosis for the use of Seroquel ate] (1). 1, the facility staff failed to gnosis for the use of Seroquel ate; (2), the facility staff failed to gnosis for the use of Seroquel admitted to the facility on oses that included but were mer's disease (2), anxiety (3), set recent MDS (minimum data sessment with an ARD noce date) of 04/19/18, coded coring a 0 (zero) on the brief status (BIMS) of a score of 0 g severely impaired of	F 75	Resident #32 and #81 have the prop diagnosis for the use of Seroquel. All residents with Physician orders for Seroquel have the potential to be affer The DON/designee to educate nursin staff/Social Workers on ensuring all residents have the correct diagnosis of psychotropic drug use. Don/designee during Morning Clinical Meeting to conduct quality monitoring 5x week x week, weekly x4 weeks and then mor PRN and indicated. Findings to be communicated to the Committee monthly and as indicated. Quality monitoring schedules modified based on findings.	octed. g for for nthly,
	ROVIDER OR SUPPLIER RELS OF BON AIR SUMMARY SUMMARY SUBJECTION CONTINUED FROM PORT CONTIN	ROVIDER OR SUPPLIER RELS OF BON AIR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 215 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure two of 32 residents was free of unnecessary medications, Residents # 32 and # 81. 1. For Resident #32, the facility staff failed to ensure a proper diagnosis for the use of Seroquel [Quetiapine Fumarate] (1). 2. For Resident #81, the facility staff failed to ensure a proper diagnosis for the use of Seroquel. The findings include: 1. For Resident #32, the facility staff failed to ensure a proper diagnosis for the use of Seroquel. The sident #32 was admitted to the facility on 08/12/16 with diagnoses that included but were not limited to Alzheimer's disease (2), anxiety (3),	ROVIDER OR SUPPLIER RELS OF BON AIR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 215 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure two of 32 residents was free of unnecessary medications, Residents # 32 and # 81. 1. For Resident #32, the facility staff failed to ensure a proper diagnosis for the use of Seroquel [Quetiapine Fumarate] (1). 2. For Resident #81, the facility staff failed to ensure a proper diagnosis for the use of Seroquel. The findings include: 1. For Resident #32 was admitted to the facility on 08/12/16 with diagnoses that included but were not limited to Alzheimer's disease (2), anxiety (3), and dysphagia (4). Resident # 32's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/19/18, coded Resident # 32 as scoring a 0 (zero) on the brief interview for mental status (BIMS) of a score of 0 - 15, 0 (zero) - being severely impaired of cognition for making daily decisions. Resident # 32 was coded as requiring extensive assistance	ROWIDER OR SUPPLIER RELS OF BON AIR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 215 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This RECULERMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility staff failed to ensure a proper diagnosis for the use of Seroquel (Quetapine Fumarate) (1). 2. For Resident #32, the facility staff failed to ensure a proper diagnosis for the use of Seroquel (Quetapine Fumarate) (1). 2. For Resident #31, the facility staff failed to ensure a proper diagnosis for the use of Seroquel (1). Resident #32 was admitted to the facility on 08/12/16 with diagnoses that included but were not limited to Alzheimer's disease (2), anxiety (3), and dysphagia (4). Resident # 32 as soring a 0 (zero) on the brief interview for metal atstatus (BIMS) of a socre of 0 - 15, 0 (zero) - being severely impaired of cognition for making daily decisions. Resident # 32 was soded as requiring sextensive assistance

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		COMPLETED
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	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BI IE APPROPRIA	DATE
F 758	Continued From pag		F 7	58		
	06/30/2018 for Residual "Quetiapine Fumara	ers dated 01/01/2018 to dent # 32 documented, te 25 MG (milligram) Tablet. by mouth two times a day for Date: 01/17/2018."				
	record) dated June 2 documented, "Queti Tablet. Give 0.5 by dementia. Start Date review of the eMAR	ic medication administration 2018 for Resident # 32 apine Fumarate 25 MG mouth two times a day for e: 01/17/2018." Further dated 06/01/18 to 06/21/18 32 received Quetiapine apportunities.				
	conducted with LPN 5. When asked wha Seroquel was LPN # LPN # 5 then review the electronic health "She is on it for dem the correct diagnosis	a.m., an interview was (licensed practical nurse) # at the indicated use for \$\frac{1}{2}\$ 5 stated, "For behaviors" and the physician's order on a record (HER) and stated bentia." When asked if it was as for the use of Seroquel LPN ause dementia can cause				
	conducted with ASM member) # 6, nurse asked what was the 6 stated, "For demeischizophrenia, bipol disorder. When ask	B a.m., an interview was I (administrative staff practitioner. When the indicated of Seroquel, ASM # ntia patient with agitation, for ar and generalized anxiety ed if a diagnosis of dementia ed use for Seroquel, ASM # 6				
		5 a.m., a telephone interview OSM (other staff member) #				

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E OF PROVIDER OR SUPPLIER LAURELS OF BON AIR			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	I	06/22/2010
EFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
dementia was appro Seroquel, OSM # 5 s intended use is on the you." On 06/21/18 at appropackage label for the provided to this surved documented, "Quetia "Indications and Usa "Schizophrenia, Bipo Considerations in Transchizophrenia and E On 06/22/18 at appropagation of the above findings. No further information References: (1) Quetiapine tablet (long-acting) tablets symptoms of schizophrenia in life, and stemotions). Quetiapine extended-release tablet with other medication (frenzied, abnormally depression in patient (manic depressive distarts).	n asked if a diagnosis of priate for the use of stated, No it is not. It's ne package label, I'll fax it to oximately 12:50 p.m., the emedication Seroquel was eyor. The package label apine Tablet." Under age" it documented, plar Disorder, Special eating Pediatric Bipolar Disorder." oximately 12:00 p.m., ASM member) # 1, administrator, nursing were made aware of on was provided prior to exit. Its and extended-release are used to treat the phrenia (a mental illness that unusual thinking, loss of trong or inappropriate ne tablets and blets are also used alone or ins to treat episodes of mania by excited or irritated mood) or its with bipolar disorder isorder; a disease that	F 758			
the above findings. No further information References: (1) Quetiapine tablet (long-acting) tablets symptoms of schizog causes disturbed or interest in life, and stemotions). Quetiapinextended-release table with other medication (frenzied, abnormally depression in patient (manic depressive dicauses episodes of comania, and other ability.	is and extended-release are used to treat the ohrenia (a mental illness that unusual thinking, loss of trong or inappropriate ne tablets and blets are also used alone or ns to treat episodes of mania y excited or irritated mood) or ts with bipolar disorder				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495394	B. WING		06/22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
F 758	tablets are also use medications to treat tablets may be used program to treat bip schizophrenia in chi Quetiapine is in a cl atypical antipsychot activity of certain na This information wa https://medlineplus.gtml. (2) A brain disorder person's ability to ca information was obt https://www.nlm.nih sease.html. (3) Fear. This information was obt https://www.nlm.nih sease.html. (4) A swallowing disobtained from the whttps://www.nlm.nih sorders.html. (5) A loss of brain fudiseases. It affects in judgment, and behallobtained from the whttps://medlineplus.gt.	etiapine extended-release d along with other depression. Quetiapine I as part of a treatment olar disorder and Idren and teenagers. ass of medications called ics. It works by changing the tural substances in the brain. s obtained from the website: gov/druginfo/meds/a698019.h that seriously affects a arry out daily activities). This ained from the website: gov/medlineplus/alzheimersdi mation was obtained from the .gov/medlineplus/anxiety.html order. This information was ebsite: .gov/medlineplus/swallowingdi inction that occurs with certain memory, thinking, language, vior. This information was	F 75	8		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION
F 758	06/24/09 with a readiagnoses that incl Alzheimer's diseas diabetes mellitus (4 anxiety (6) and and Resident # 81's moset), a quarterly as (assessment references Resident # 81 as a interview for mentary - 15, 3 (three) - beincognition intact for Resident # 81 was assistance of one sident # 81 docu (Quetiapine Fumar by mouth two times Start Date: 06/15/2 The eMAR (electron record) dated June documented, "Sero Give 12.5 mg by modisorder. Start Date of the eMAR dated Resident # 81 rece of nine opportunities." On 06/21/18 at 8:5 conducted with LPI 5. When asked who Seroquel was LPN LPN # 5 then reviews.	admitted to the facility on admission of 03/30/11 with uded but were not limited to e (2) hypertension (3), 4), depressive disorder (5), emia (7). In the set recent MDS (minimum data sessment with an ARD ence date) of 05/23/18, coded coring a 3 (three) on the brief all status (BIMS) of a score of 0 mg severely impaired of making daily decisions. coded as requiring extensive staff member for activities of the state (Big 1) and the set of the set o	F 75	8	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		DATE SURVEY COMPLETED	
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F 758	"She is on it for demithe correct diagnosis # 5 stated, "Yes becabehaviors." On 06/21/18, at 8:58 conducted with ASM member) # 6, nurse asked what was the 6 stated, "For demer schizophrenia, bipola disorder. When asked would be an indicate stated, "No." On 06/21/18 at 11:25 was conducted with 5, pharmacist. When dementia was appro Seroquel, OSM # 5 s intended use is on thyou." On 06/21/18 at appropackage label for the provided to this surved documented, "Quetia "Indications and Usa "Schizophrenia, Bipo Considerations in Tre Schizophrenia and E On 06/22/18 at appropackage label for the provided to the surved documented, "Quetia "Indications and Usa "Schizophrenia, Bipo Considerations in Tre Schizophrenia and E On 06/22/18 at appropagation of the above findings."	entia." When asked if it was for the use of Seroquel LPN ause dementia can cause a.m., an interview was (administrative staff practitioner. When the indicated of Seroquel, ASM # atia patient with agitation, for ar and generalized anxiety ed if a diagnosis of dementia d use for Seroquel, ASM # 6 5 a.m., a telephone interview OSM (other staff member) # asked if a diagnosis of priate for the use of stated, No it is not. It's the package label, I'll fax it to expect to be provided in the pro	F 7	758			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 758	(long-acting) tablets symptoms of schizo causes disturbed or interest in life, and semotions). Quetiapi extended-release tawith other medication (frenzied, abnormal depression in patier (manic depressive of causes episodes of mania, and other at quetiapine tablets are used with other episodes of mania of bipolar disorder. Quetiapine tablets are also use medications to treat tablets may be used program to treat bip schizophrenia in chaptical antipsychological	ets and extended-release are used to treat the sphrenia (a mental illness that runusual thinking, loss of strong or inappropriate ne tablets and ablets are also used alone or ons to treat episodes of mania ly excited or irritated mood) or nts with bipolar disorder disorder; a disease that depression, episodes of onormal moods). In addition, and extended-release tablets medications to prevent or depression in patients with metiapine extended-release d along with other d das part of a treatment holar disorder and ildren and teenagers. lass of medications called dicts. It works by changing the matural substances in the brain. Is obtained from the website: gov/druginfo/meds/a698019.h that seriously affects a marry out daily activities) This mained from the website: gov/medlineplus/alzheimersdi sure. This information was	F 758			

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		495394	B. WING_			06/	22/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE LAUF	RELS OF BON AIR				01 BON AIR CROSSINGS DRIVE		
				В	ON AIR, VA 23235		
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F 758	essure.html. (4) A chronic disease regulate the amount of information was obtain	in which the body cannot of sugar in the blood. This	F	758			
	blue, unhappy, misera Most of us feel this washort periods. Clinical disorder in which feel or frustration interfered or more. This information website: https://medlineplus.go. (6) Fear. This information website: https://www.nlm.nih.go.	the described as feeling sad, able, or down in the dumps. The arrow are time or another for all depression is a mood ings of sadness, loss, anger, with everyday life for weeks ation was obtained from the abovency/article/003213.htm. The ation was obtained from the action was obtained from the action.					
F 842 SS=E	the website: https://www.nlm.nih.g . Resident Records - Ic CFR(s): 483.20(f)(5), §483.20(f)(5) Resider (i) A facility may not re resident-identifiable to accordance with a co- agrees not to use or co-	483.70(i)(1)-(5) nt-identifiable information. elease information that is to the public. lease information that is	F 8	842			8/3/18

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVE		
		495394	B. WING		06/22/20	118	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 00722720		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COM	(X5) IPLETION DATE	
F 842	professional standar must maintain medic that are- (i) Complete; (ii) Accurately docum (iii) Readily accessib (iv) Systematically or \$483.70(i)(2) The fact all information contains regardless of the formation contains regardless of the formation contains and the fact of the formation contains and the fact of the formation contains and the fact of the f	ecords. Indance with accepted designed and practices, the facility all records on each resident dented; le; and aganized designed in the resident's records, and or storage method of the in release isor their resident designed permitted by applicable law; anyment, or health care ted by and in compliance	F 84	42			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG		
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F 842		ne date of discharge when	F 8	42		
	there is no requireme (iii) For a minor, 3 ye legal age under State	ars after a resident reaches				
	(i) Sufficient informat (ii) A record of the re	edical record must contain- ion to identify the resident; sident's assessments; ive plan of care and services				
	(iv) The results of an and resident review determinations cond	ucted by the State;				
	professional's progre (vi) Laboratory, radio	e's, and other licensed ess notes; and logy and other diagnostic equired under §483.50.				
	by: Based on staff interv	T is not met as evidenced view, facility document review		Resident #22 scopolamine pa		
	the facility staff failed accurate medical red	eview, it was determined that I to maintain a complete and cord for four of 32 residents in Resident #22, 308, 102 and 6.		place and documented on the medical record. Resident #308 corrected. Resident #102s me are being documented on the	3 has been edications medical	
	The facility staff far placement of the sco	polamine patch was		record. Catheter care is being and documented on Resident	#6.	
	checked as directed administration record 2018, for Resident #	d on 7 occasions in June		All residents have the potentia affected. DON/designee to educate number following Physician orders for	sing staff on	
	plan intended for and	iled to ensure that a care other resident was not plan for Resident #308.		administration and documenta as catheter care and documer medical record. DON/designe morning clinical meeting to co	ntation in the ee during	
	3. The facility staff fa administration of sch Resident # 102.	iled to document the eduled medications for		monitoring 5x week x1 week, weeks and then monthly, PRN indicated. Findings to be communicated	weekly x4 I and	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
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F 842	Continued From pag	ge 225	F 842	2		
	_	ailed to document that ompleted for Resident #6 on June of 2018.		committee monthly and as in Quality monitoring schedules based on findings.		
	The findings include	:				
	2/23/17 with diagnost limited to: multiple so pressure, depressionstroke and insomnia. Review of the most set), an annual asset (assessment reference)	recent MDS (minimum data essment, with an ARD nce date) of 4/3/18, coded the				
	BIMS Brief interview	cored a 13 out of 15 on the for mental status) indicating gnitively intact to make daily				
	documented, "SCOF (milligrams)/3DAY P transdermally one til increased secreation	ATCH Apply 1 patch me a day every 3 day(s) for ns (sic) and remove per ocumented that the patch had				
	administration reconsum "SCOPOLAMINE (1) PATCH Apply 1 pate day every 3 day(s) for and remove per schittant the patch had but be a placement of Scopolamine There was no evidente."	018 MAR (medication d) documented,) 1MG (milligrams)/3DAY th transdermally one time a or increased secreations (sic) edule." It was documented een applied every three days. e MAR documented, "Check lamine Patch every shift." nce of documentation that the cked on 7 occasions as				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	' '	OMPLETED
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	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	•	00/22/2010
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F 842	evidenced by blank An interview was cop.m. with LPN (licenresident's nurse. Whon the MAR meant, that it was not docurasked to review Rescopolamine patch, just didn't document An interview was cop.m. with LPN #3. We spaces on the MAR "Looking at it, looks forgot to document in important to have at LPN #3 stated, yes to know how the resconfindings. A request we complete and accurate ASM #2 at that time On 6/22/18 at 2:35 provided in the complete and accurate and accurate and in the complete and in t	spaces on the MAR. Inducted on 6/21/18 at 12:40 sed practical nurse) #8, the nen asked what a blank space LPN #8 stated that it could be mented or not done. When sident #22's MAR for the LPN #8 stated she probably it. Inducted on 6/22/18 at 2:01 I/hen asked what blank meant, LPN #3 stated, like it was never done or they t." When asked if it was n accurate clinical record, because it was a way for staff ident was doing. p.m. ASM (administrative ne administrator and ASM #2, ng were made aware of the vas made for a policy on ate medical records from o.m. ASM #5, the director of isted facility stated, "We don't implete and accurate medical on was provided prior to exit. copolamine is an alkaloid if, especially DATURA and amine and its quaternary	F	342		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495394	B. WING		C 06/22/2018
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 842	anesthetic premedica INCONTINENCE, in antispasmodic, and a cycloplegic. This info	ng the many uses are as an ation, in URINARY MOTION SICKNESS, as an as a mydriatic and rmation was obtained from: .nlm.nih.gov/compound/scop	F 84	42	
	plan intended for and included on the care Resident #308 was a 6/6/18 with diagnose limited to: irregular he failure, high blood proceed to the resident as having the principle of the resident as having the brief interview for indicating the resident make daily decisions requiring assistance daily living with the eresident could perform prepared. Review of the resider 6/6/18 and revised of ADL (activities of dail Requires 1-2 person)	S (minimum data set), an nt, with an ARD ce date) of 7/13/18 coded g scored a 14 out of 15 on mental status (BIMS) at was cognitively intact to . The resident was coded as from staff for all activities of exception of eating which the mafter the tray was nt's care plan initiated on 16/1/18 documented, "Need. y living) PREF (preference):			

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F 842	Review of the June not evidence docur tube. Review of the June documentation regards and interview was carea. Mere and the unit manager. Very a PEG tube, LPN # to review the above "That was put in wrwas supposed to be resident), I put that was important for the RN #1 stated it guid resident. On 6/22/18 at 12:10 staff member) #1, the director of nursifindings. No further information. PEG Percutan (PEG) is the preferent nutritional support in gastrointestinal system enteral nutrition. Be advantages over passuperior access to over surgical methodobtained from: https://www.ncbi.nli.69302/	2018 physician's orders did nentation regarding a PEG 2018 MAR did not evidence	F8	42		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 842	administration of sch Resident # 102. Resident # 102 was 02/10/15 with a read diagnoses that include respiratory failure (1) gastroesophageal redisorder (4), anxiety Resident # 102's modata set), a quarterly (assessment referent Resident # 102 as so interview for mental set) - 15, 14 - being cogn decisions. Resident independent and redistant independent and redistant record) for Resident to evidence the following administered to Resi Prednisone* (treats in Spiriva* (used for as Augmentin* (for pnet) Buspirone* (for anxied) Dicyclomine* (for anxied) Dicyclomine* (for irrito6/10/18. Ferrous Sulfate* (for Florastor* (probiotic) Lantus* (insulin) on Company Spironolactone* (for Albuterol* (for asthmatical Enulose Solution* (for 06/09/18 and 06/10/18)	admitted to the facility on mission of 11/30/17 with ded but were not limited to diabetes mellitus (2), and anemia (6). Ist recent MDS (minimum assessment with an ARD ace date) of 06/01/18, coded coring a 14 on the brief status (BIMS) of a score of 0 ditively intact for making daily # 102 was coded as being quiring the assistance of one vities of daily living. Ic medication administration # 102 dated June 2018 failed wing medications were ident # 102 inflammation) on 06/10/18. The date of th	F8	42		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	. ,	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	I	00/22/2010	
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F 842	Continued From pa	age 230	F 84	2			
	conducted with RN reviewing the EMA Resident # 102 and a.m. to 3:00 p.m., s RN # 2 was what the stated, "It appears medication was given on 06/22/18 at 8:3 was conducted with nurse) # 5 regarding the EMAR for Residual ministration on 05 stated she did wo p.m., shift on 06/09 asked about the blatter 7:00 a.m. to 3:00	0 a.m., a telephone interview in LPN (licensed practical ingular flow) gher lack documentation on dent # 102's medication 16/09/18 and 06/10/18. LPN # 100 or the 7:00 a.m. to 3:00 10/18 and 06/10/18. When the left on the EMAR during 100 p.m., shift on 06/09/18 and 100 or the left on the left o					
	(administrative staf ASM # 2, director of the above findings.	proximately 12:00 p.m., ASM f member) # 1, administrator, of nursing were made aware of ion was provided prior to exit.					
	References: (1) A long-term disc of the joints and su affect other organs obtained from the v https://medlineplus (2) A chronic disea regulate the amour	ease. It leads to inflammation rrounding tissues. It can also . This information was					

PRINTED: 07/20/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495394	B. WING	B. WING		I	22/2018
	ROVIDER OR SUPPLIER		1	9	STREET ADDRESS, CITY, STATE, ZIP CODE 0101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235	1 001	22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	(3) Stomach contents the esophagus and in was obtained from the https://www.nlm.nih.g (4) Depression may be blue, unhappy, misera Most of us feel this wishort periods. Clinical disorder in which feel or frustration interfered or more. This information website: https://medlineplus.gd (5) Fear. This informations: https://www.nlm.nih.gr/summary. (6) Low iron. This informations the website: https://www.nlm.nih.gr/summary. 4. The facility staff fair catheter care was conseveral occasions in a Resident #6 was adm 12/6/17 with diagnose limited to end stage retype two diabetes and pulmonary disease). MDS (minimum data quarterly assessment)	ov/medlineplus/ency/article/ to leak back, or reflux, into ritate it. This information we website: ov/medlineplus/gerd.html. see described as feeling sad, able, or down in the dumps. ay at one time or another for all depression is a mood ings of sadness, loss, anger, with everyday life for weeks ation was obtained from the ov/ency/article/003213.htm. ation was obtained from the ov/medlineplus/anxiety.html ormation was obtained from ov/medlineplus/anemia.html led to document that impleted for Resident #6 on June of 2018.	F	842			

l ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BON AIR CROSSINGS DRIVE 3ON AIR, VA 23235	1 001	22/2010
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F 842	make daily decisions 15 on the BIMS (Brie exam. Review of Resident # order summary) docu "Foley catheter 18 F cath (catheter) care exam (catheter) care exam (blank spaces) for the 6/1/18 night shift, 6/6/18 day shift, 6/10/18 night shift, 6/12/18 at 12:00 p conducted with Resident #6's nurse. The conducted with LPN Resident #6's nurse. The conducted with the staff did his conducted with LPN Resident #6's nurse. The conducted with the staff did his conducted with LPN Resident #6's nurse. The conducted with the staff did his conducted with LPN Resident #6's nurse. The conducted should be document that the the treatment administration what blanks meant on that it meant that the the treatment was not that it should be document to the conducted with the the treatment was not that it should be document that the the treatment was not that it should be document that the the treatment was not that it should be document that the the treatment was not that it should be document that the the treatment was not that it should be document that the the treatment was not that it should be document that the the treatment was not that it should be document that the the treatment was not that it should be document that the the treatment was not that it should be document that the the treatment was not that it should be document that the the treatment was not that it should be document that the the treatment was not that it should be document that the treatment was not that it should be document th	itively intact in the ability to scoring 15 out of possible f Interview for Mental Status) 26's June POS (physician amented the following order: (French), 10 cc balloon. With every shift." 26's June 2018 TAR ation record) revealed holes are following dates and times: 26.m., an interview was dent #6. Resident #6 stated catheter care every shift.	F	842			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			SURVEY PLETED			
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		495394	B. WING _		06.	/22/2018
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F 842 F 880 SS=D	DON (Director of Nur- Regional Director of C aware of the above co Potter and Perry's Fu edition) pg.482 states reflect accountability entryThe entry nee	e administrator, ASM #2, the sing), and ASM #4, the Operations, were made oncerns. Indamentals of Nursing (6th s, "(Clinical) Records need to during the time frame of the eds to clearly show what was one, and by whomMost use military time."	F 8			8/3/18
	§483.80 Infection Cor The facility must esta infection prevention a designed to provide a comfortable environm development and trar diseases and infection §483.80(a) Infection program. The facility must esta and control program (a minimum, the follow §483.80(a)(1) A syste reporting, investigatin and communicable di staff, volunteers, visite providing services un arrangement based u	introl iblish and maintain an and control program a safe, sanitary and ment and to help prevent the asmission of communicable ins. prevention and control iblish an infection prevention (IPCP) that must include, at wing elements: em for preventing, identifying, and controlling infections iseases for all residents, ors, and other individuals ider a contractual upon the facility assessment				
	accepted national sta	to §483.70(e) and following andards; n standards, policies, and				

AND DUAN OF CODDECTION		` ′	PLE CONSTRUCTION G	l ^{(×}	(X3) DATE SURVEY COMPLETED	
		495394	B. WING			C 06/22/2018
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F 880	procedures for the probut are not limited to (i) A system of surve possible communica infections before the persons in the facility (ii) When and to who communicable disea reported; (iii) Standard and trato be followed to pre(iv)When and how is resident; including by (A) The type and durdepending upon the involved, and (B) A requirement the least restrictive possic cumstances. (v) The circumstance must prohibit employ disease or infected scontact with resident contact will transmit (vi)The hand hygiene by staff involved in d §483.80(a)(4) A systidentified under the from the corrective actions tales (§483.80(e) Linens. Personnel must hand transport linens so a infection.	rogram, which must include, illance designed to identify ble diseases or y can spread to other // m possible incidents of se or infections should be nsmission-based precautions vent spread of infections; olation should be used for a ut not limited to: ration of the isolation, infectious agent or organism at the isolation should be the ible for the resident under the es under which the facility rees with a communicable kin lesions from direct s or their food, if direct the disease; and e procedures to be followed irect resident contact. em for recording incidents acility's IPCP and the ken by the facility. dle, store, process, and is to prevent the spread of	F 8	80		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 880	This REQUIREMENT by: Based on observation document review and was determined that maintain infection coresident in the survey. The facility staff failed changing gloves durit tracheostomy care. The findings include: Resident # 64 was an 02/14/18 with a reading diagnoses that include malignant neoplasm gastroesophageal resobstructive pulmonar (5) and benign prostated. Resident # 64's most set), a quarterly asset (assessment referencesident # 64 as socion interview for mental set), a quarterly asset (assessment referencesident # 64 as socion interview for mental set). The set of daily living treatment, Procedured the set of daily living treatment the set of	ir program, as necessary. I is not met as evidenced In, staff interview, facility Id clinical record review, it It the facility staff failed to Introl practices for one of 32 If sample, Resident # 64. Id to wash their hands after Ing Resident # 64's Idmitted to the facility on Inission of 03/13/18 with Ided but were not limited to Introl practices for one of 32 If the wash their hands after Ing Resident # 64's Idmitted to the facility on Inission of 03/13/18 with Ided but were not limited to Introl practices (1) In the larynx (2) In the larynx (2) In the larynx (3) In the larynx (4) In the larynx (5) In the larynx (6) In the larynx (7) In the larynx (8) In the lary	F 88	The facility staff are washing their hafter changing gloves during resider #64s tracheostomy care. All residents have the potential to be affected. DON/ designee to re-educate nurse infection control including handwash DON/designee to conduct quality monitoring 5x week x1 week, weekly weeks and then monthly, PRN and indicated. Findings to be communicated to the committee monthly and as indicated Quality monitoring schedules modificated on findings.	es on hing. 7 x4 QA

PRINTED: 07/20/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

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F 880	hands, donned a pair "Tracheostomy Clean on an over-the-bed ta LPN # 6 remover her trash can, opened on Cleaning Kits", remove and put then on, loos collar, removed the caleaning tray containing LPN #6 then cleaned opening in Resident # removed the sterile gover and put cannula and reattach supplies, placed them gloves and washed hor on 06/22/18 at approinterview was conductasted to describe the changing gloves LPN hands each time you I didn't do that." The facility's policy "L" "4. Wash hands after do not replace hand work on 06/22/18 at approinterview was conductable to the changing gloves LPN hands each time you I didn't do that." The facility's policy "L" "4. Wash hands after do not replace hand work on 06/22/18 at approinterview staff in ASM # 2, director of in the above findings. No further information References:	LPN # 6 initially washed her of gloves, gathered two sing Kits" and placed them able with a clean barrier. gloves, placed them into the e of the "Tracheostomy yed the pair of sterile gloves ened the tracheostomy annula, and placed it in the ng the cleaning solution. the cannula and around the 464's throat. LPN #6 then loves, opened the other g kit, removed the pair of then on, replaced the clean ed the collar, picked up the in the trash, removed her er hands. ximately 7:40 a.m., an atted with LPN # 6. When the procedure followed when # 6 stated, "Wash your change your gloves. I know Using Gloves" documented, removing gloves. Gloves	F	380			

AND BLAN OF CORRECTION LIDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	` '	CX3) DATE SURVEY COMPLETED C	
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F 880	to other sites in the linvade nearby (local Malignant cells tend growth and DO NOT in their genetic make resistant to treatmer detectable traces of destroyed. This in the website: https://medlineplus.g. (2) The larynx, or vo and performs several body. The larynx is in breathing, and voice produced when the vocal cords causes sound waves in the The pitch of sound is of tension on the vowas obtained from the https://medlineplus.g. htm. (3) Stomach content the esophagus and was obtained from the https://www.nlm.nih. (4) Disease that make can lead to shortness was obtained from the https://www.nlm.nih.	nat have the ability to spread body (metastasize) or to ally) and destroy tissues. It is have fast, uncontrolled die normally due to changes eup. Malignant cells that are not may return after all them have been removed or afformation was obtained from gov/ency/article/002253.htm. Sice box, is located in the neck all important functions in the nvolved in swallowing, a production. Sound is air which passes through the them to vibrate and create pharynx, nose and mouth. It is determined by the amount call folds. This information he website: By gov/ency/imagepages/19708. This information he website: By gov/medlineplus/gerd.html. This information he website: By gov/medlineplus/gerd.html.	F 88	30		

AND DUAN OF CODDECTION			PLE CONSTRUCTION G	(X3	(X3) DATE SURVEY COMPLETED	
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F 880	the lungs. This tube or trach tube This if from the website: https://medlineplus.g	is called a tracheostomy tube information was obtained nov/ency/article/002955.htm.	F 8	80		